Pacific Pediatrics Medical Group

Notice of Privacy Practices Patient Receipt

Your signature on this document acknowledges that you have received a copy of the Pacific Pediatrics Medical Group Notice of Privacy practices.

Our Notice of Privacy Practices provides you with information about how Pacific Pediatrics may use or disclose your protected health information. We encourage you to read it in full.

Name of Patient: _____

Name of Guardian if patient is a Minor: _____

Signature: _____

Date: _____