

PRIMARY CARE PEDIATRICS, P.C.

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HIPPA Patient Acknowledgement

I have read and understand the Notice of Privacy Practices of Primary Care Pediatrics. I understand that I have rights outlined in this notice and can request a copy of this notice for my own personal records. I accept this notice as a protection of my child's medical information.

Signature of Parent or Guardian

Date

Children this Acknowledgement Protects:

_____	_____	_____
_____	_____	_____
_____	_____	_____

6/15/10