

## Privacy Practices Notice Acknowledgment of Receipt

By signing below I acknowledge that I have received a copy of Stepping Stone Pediatrics' Notice of Privacy Practices for protected health information.

Date:	_
Patient #1:	
NAME	_DOB
Patient #2:	
NAME	_DOB
Patient #3	
NAME	_DOB
Patient #4:	
NAME	DOB
Signature of Parent:	
Relationship to Patient(s):	