



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):
