

**Acknowledgement of Reception of Privacy Notice**

On this date, I \_\_\_\_\_ received a copy of Amherst Pediatric Associates NOTICE OF PRIVACY PRACTICES, given to me in accordance with the Federal Government's mandate contained in the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (compliance date 4/14/03).

My signing this form acknowledges only my physical reception of the Notice and in no way indicates or presumes that I have read or agree with its contents.

Patient(s) Name(s) \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Names: Mother: \_\_\_\_\_  
Father: \_\_\_\_\_

Name: print \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Staff Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Refusal of Privacy Notice**

On this date I was offered a copy of Amherst Pediatrics NOTICE OF PRIVACY PRACTICES, in accordance with the Federal Mandate contained in the Health Insurance Portability and Accountability Act of 1996. (Compliance date 4/14/03)

***I refuse to physically accept this Notice.***

Patient(s) Name(s) \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Names: Mother: \_\_\_\_\_  
Father: \_\_\_\_\_

Name: print \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Staff Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_