

# *Primary Pediatric Medical Group, Inc.*

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## **ACKNOWLEDGEMENT OF RECEIPT**

### **PRIMARY PEDIATRIC MEDICAL GROUP PRIVACY PRACTICES POLICY**

I HAVE RECEIVED A COPY OF PRIMARY PEDIATRIC MEDICAL GROUP'S  
NOTICE OF PRIVACY PRACTICES.

PATIENT NAME \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

(Please Print)

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_