



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_ acknowledge that I have read the attached copy of the Leon Springs Pediatrics "Notice of Privacy Practices." This notice describes how LEON SPRINGS PEDIATRICS may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name of Signature Guarantor

\_\_\_\_\_  
Date