WONDERKIDS PEDIATRICS

ACKNOWLEDGEMENT OF PRIVACY POLICY AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by WONDER KIDS PEDIATRICS, PLLC, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Please print the name and DOB of each child who is seen at this practice.

Patient Name _____Date of Birth_____

Patient Name_____Date of Birth_____

Patient Name_____Date of Birth _____

Patient Name_____Date of Birth_____

Patient Name:_____Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____