ISLAND HEIGHTS PEDIATRICS
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I acknowledge that I was provided a copy of the Notice of Privacy Practices for Island Heights Pediatrics, PC.

Print name of patient		Date:	
Signature of patient			

If person signing is not the patient, please print your name and relationship to patient:

Name		Relationship	

I (patient or representative) request a copy of the Notice of Privacy Practices:

YES	NO

May we leave a message? (circle all that apply)	Appointments	Test Results	Other medical information

I make the following special request for confidential communications:

_____

_____

_____

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For Office Use:

If patient/representative requested copy of Notice, date copy was provided: _____

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain acknowledgment:

_____

_____