

# McKinney Pediatrics, P.A.

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## Notice of Privacy Practices (HIPPA) Acknowledgement

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I acknowledge that McKinney Pediatrics provided me with a written copy of the practice's Notice of Privacy Practices.

I also acknowledge that I have been given the opportunity to read the Notice of Privacy Practices and ask questions.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient