PRIVACY STATEMENT ACKNOWLEDGEMENT

I acknowledge Great River Pediatric Clinic provided me a copy its notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights i have regarding my protected health information.

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Signature of Patient or Parent/Guardian/Personal Representative

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Name of Patient or Parent/Guardian/Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date  
Please list all children along with date of birth: