MVPT FOR KIDS, PLLC
PEDIATRIC THERAPY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a ***Notice of Privacy Practices for Protected Health Information also known as "PHI"*** which provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

_____ _____

Patient Printed Name **Date**

_____ _____

Patient Signature **Date**

_____ _____

Patient Representative and/or Legal Guardian Printed Name
(If patient is unable to sign and /or if patient is a minor) **Date**

_____ _____

Patient Representative and/or Legal Guardian Signature
(If patient is unable to sign and /or if patient is a minor) **Date**