Pediatric Gastroenterology of Charleston

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I,_____ or_____, parent / guardian of

(Patient name) (parent/guardian)

_____ have reviewed /received a copy of Pediatric

(Patient name)

Gastroenterology of Charleston Notice of privacy practices.

_____ _____

Signature of patient Date

_____ _____

Signature of parent/ guardian Date