CAPITAL DISTRICT PEDIATRIC CARDIOLOGY, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Capital District Pediatric Cardiology, PC Notice of Privacy Practices. This notice describes how Capital District Pediatric Cardiology, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

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Name of patient

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Patient signature or personal representative

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Relationship to patient

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Date