southwest pediatrics

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NOTICE OF PRIVACY PRACTICES RECEIPT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I HAVE RECEIVED THE ATTACHED COPY OF SOUTHWEST PEDIATRICS, LTD's PRIVACY PRACTICES THAT BECOME EFFECTIVE ON MARCH 3, 2003.

Last Name, First Name (Please list each child)	Birth Date	Date

_____ _____
Print Name of Parent/Legal Guardian **DATE**

_____ _____
Signature or Parent/Legal Guardian **DATE**

_____ _____
Witness **DATE**

Southwest Pediatrics, LTD.
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Answering Service
(708) 857-2844

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FOR OFFICE USE ONLY:
I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:
DATE: _____ INTIALS _____ REASON: _____