Kenneth J. Kim Pediatrics
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Acknowledgement of Receipt of Notice of Privacy Practices and Authorization to Release Protected Health Information

This form is to acknowledge that I had an opportunity to review the Notice of Privacy Practices which describes how the patient's protected health information may be used or disclosed. I authorize Kenneth J Kim Pediatrics to use and share the patient's protected health information to treat, bill insurance companies for payment, and operate our practice for the purpose of providing best medical care. I am aware that I may ask a copy of the Notice of Privacy Practices which is also published in the practice's website.

Patient's Name: _____ **Date of Birth:** ____/____/_____

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Patient's Name: _____ **Date of Birth:** ____/____/_____

_____ _____
Signature of Parent or Legal Guardian/ Patient (if 18 or older) Relationship to Patient

_____ _____
Print Name of Person Signing Date