ACKNOWLEDGEMENT OF RECEIPT
OF
WYOMING SPRINGS PEDIATRICS

NOTICE OF PRIVACY POLICY
AND
PATIENT AUTHERIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I am in receipt of Wyoming Springs Pediatrics' Notice of Privacy Policy.

_____ _____

Signature Date

I understand that Wyoming Springs Pediatrics will only use and/or disclose protected health information (PHI) for treatment, payment, of healthcare operations.

_____ _____

Signature Date

Please List all children in our practice.

NAME	DATE OF BIRTH