



# KinderHealth, LLC

## Notice of Privacy Practices

### Receipt and Acknowledgment of Notice

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for this office. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full and ask any questions you may have. If you have any questions regarding the Notice of Privacy Practices, you may contact Odun Olalere, CRNP at [kinderhealth@outlook.com](mailto:kinderhealth@outlook.com).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian/Guarantor)

### Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Staff member)