

Lakeside Pediatric & Adolescent Medicine, PLLC  
Receipt of Notice of Privacy Practices  
Written Acknowledgement Form

I, (We) \_\_\_\_\_, \_\_\_\_\_  
Parent or guardian name Parent or guardian name

Have received a copy of LAKESIDE PEDIATRIC & ADOLESCENT MEDICINE, PLLC's  
Notice of Privacy Practices.

\_\_\_\_\_  
**Patient Name** D.O.B. \_\_\_\_\_

\_\_\_\_\_  
Signature **Mother**/Guardian Date

\_\_\_\_\_  
Signature **Father**/Guardian Date