University Pediatric Associates

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NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM RECEIVED.

I, _____, have received a copy
(Patients Name)

of University Pediatric Associates Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian **DATE**

SIGNATURE ON FILE INSURANCE AUTHORIZATION

I authorize payment of medical benefits to:
University Pediatric Associates for Medical Service(s) provided.

_____ _____
Signature of insured (or) Authorized Person **DATE**