



**ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Sunshine Valley Pediatrics Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

\_\_\_\_\_  
Patient Name (Type or Print)

\_\_\_\_\_  
Patient’s Date of Birth

\_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Date