

Lakeview Pediatrics, LLC
Notice of HIPAA PRIVACY POLICY

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Parent or Legal Guardian: _____

Date: _____

Date of birth:

Print Name of Patients:	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Print Name of Parent or Legal Guardian _____