GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that the *Notice of Privacy Practices* was made available to you for review prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your/your child's medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my/my child's information:

_____

_____

_____

_____

_____

Patient Name: _____ Patient Date of Birth: _____

Parent/Guardian's Signature: _____Date:_____