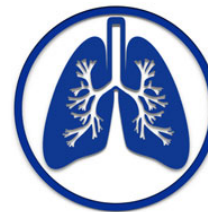




**Peter N. Schochet, MD**  
**Hauw S. Lie, MD**

**Board Certified Pediatric Pulmonologists**



Notice of Office Privacy Practice  
Acknowledgement Receipt

I \_\_\_\_\_ acknowledge that I have reviewed a copy of the “Notice of Privacy Practices of Peter Schochet, MD, PA”.

This Notice describes how Peter Schochet, MD, PA may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

In addition, I have been offered a copy of the Notice of Privacy of Peter Schochet, MD, PA.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Name of Patient)

**Pediatric Pulmonologists**

Peter N. Schochet, MD & Hauw S. Lie, MD

6130 West Parker Road, Suite 505, Plano, Texas 75093

**972-981-3251 • 972-981-3254 FAX • [www.pedilung.com](http://www.pedilung.com)**