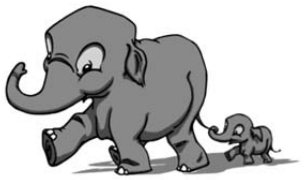

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Brent K. Tamamoto, M.D.
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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY POLICIES AND PRACTICES
FOR

AIEA PEDIATRICS LLC
BRENT K. TAMAMOTO, M.D.

I have read the Notice of Privacy Policies and Practice (the "Notice") that is available in the office of Aiea Pediatrics LLC. I was informed that I may also obtain a printed copy of the Notice from any Staff Member. I hereby acknowledge that I have read and/or received from the office of Brent K. Tamamoto, M.D. a copy of the Notice.

I authorize the office of Brent K. Tamamoto M.D. to contact me at Home, Cellular, or Business number concerning any test results, appointment reminders, scheduling, and/or any medical information.

NAME OF PATIENT	SIGNATURE (Not necessary if younger than 18)
NAME OF PERSON SIGNING IF NOT PATIENT	SIGNATURE
RELATIONSHIP TO PATIENT	DATE

OPTIONAL

I also authorize the office of Brent K. Tamamoto, M.D. to also disclose and discuss any information regarding my medical care, including appointments and financial concerns, to any person listed below:

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

NAME OF AUTHORIZED PERSON	RELATIONSHIP TO PATIENT
CONTACT NUMBER	DATE

SIGNATURE OF PARENT OR LEGAL GUARDIAN