Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Pediatrics and Adolescent
(Print Name)
Medicine, PC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Jon Charron
(203) 795-6025

I also understand that I am entitled to receive updates upon request if Pediatrics and Adolescent Medicine, PC amends or changes its Notice of Privacy of Practices in a material way.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient, if signed by someone other than the patient.

This section is to completed by Pediatrics and Adolescent Medicine, PC if unable to obtain written acknowledgement from patient

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

( ) Patient declined to sign this Written Acknowledgement
( ) Other (specify):_____

_____ _____
Name of Employee Date