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 Center for Pediatric 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:

Matthew Carreira, Practice Manager
(203) 798-7661

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

____ _______________________________

Signature Relationship to patient

____

Today's date

Please list children's names and dates of birth:

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THIS SECTION IS TO BE COMPLETED BY CENTER FOR PEDIATRIC MEDICINE, PC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT 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 & title of employee Date