

NOTICE of PRIVACY PRACTICES



Acknowledgment of Receipt

Print Full Name of Patient _____	Date		
	Month	Day	Year

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 New England Pediatrics 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:

**Practice Manager
203 972-5232**

I also understand that I am entitled to receive updates upon request if New England Pediatrics amends or changes its Notice of Privacy Practices in a material way.

Name of Responsible Party: _____
Please Print

Relationship to Patient: _____

Parent or Guardian Signature: _____

Date: _____

This Section Is To Be Completed By New England Pediatrics If Unable To Obtain Written Acknowledgement From Patient

I made a good faith effort to obtain a written acknowledgment of receipt of the notice of privacy practices from the above-named patient, but was unable to because:

Patient declined to sign this written acknowledgment.

Other (*Specify*): _____

Name of Employee _____

Title of Employee _____

Date _____