

## NOTICE OF PRIVACY PRACTICES Acknowledgment of Receipt

This document is to be signed by a person legally responsible for the following patients' medical decisions:

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT NAME

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:

**PRIVACY CONTACT:** Patti Delaney 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: \_\_\_\_\_

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 \_\_\_\_\_