ACKNOWLEDGMENT 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, _____, (patient's name) hereby acknowledge that Pediatric & Medical Associates, P.C. 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:

Pediatric & Medical Associates, P.C.
HIPAA Compliance Office
(203) 865-3737

I also understand that I am entitled to receive updates upon request if Pediatric & Medical Associates, P.C. amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature

Relationship to Patient, if signed by someone other than patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY PEDIATRIC & MEDICAL ASSOCIATES, P.C. IF UNABLE TO OBTAIN WRITTEN ACKNOWLDGEMENT 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 and title of employee

Date