

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.

CHILDREN'S NAMES (please list)

_____	_____
_____	_____
_____	_____

I, _____, hereby acknowledge that Stamford Pediatric 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:

**Privacy Contact
203-324-4109**

I also understand that I am entitled to receive updates upon request if Stamford Pediatric 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.

Print Name

Date

THIS SECTION IS TO BE COMPLETED BY STAMFORD PEDIATRIC ASSOCIATES 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 and title of employee

Date