DOCTORS' PEDIATRIC, P.C.

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, _____ hereby acknowledge that Doctors' Pediatric, P.C. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about my family may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Jane Vaum/ Practice Administrator
203-762-3363

I also understand that I am entitled to receive updates upon request if Doctors' Pediatric, 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 DOCTORS' PEDIATRIC, P.C., IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM THE 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