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.

PATIENT NAME: _____ DOB _____

I, _____, hereby acknowledge that Ridgefield Pediatric Associates 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 Practice Contact
203 438-9557

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

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

_____
Date

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE

___ Given to above signee
___ Sent home via US Mail

In either situation the parent/legal guardian must sign and return to Ridgefield Pediatric Associates, 38B Grove Street, Ridgefield, CT 06877, Attn: HIPAA Contact

THIS SECTION IS TO BE COMPLETED BY RIDGEFIELD 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 and title of employee Date