

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 [Guilford 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:

[The Privacy Officer at Guilford Pediatrics] [203-453-5235]

I also understand that I am entitled to receive updates upon request if [Guilford Pediatrics] 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 [Guilford 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

