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 The Center for Advanced Pediatrics, P.C. (C.A.P.) has either offered me or 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:

C.A.P.'s Privacy Contact at 203-229-2029

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

______________________________ ______________________________

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

____

Date

Names of Patients: ______________________________

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

- o Given to above signee
- o Sent home via U.S. Mail
- o Advised person bringing in patient that policy is available on our website www.thecenterforadvancedpediatrics.com

In either situation the parent/legal guardian must sign and return to The Center for Advanced Pediatrics, 761 Main Avenue, Norwalk, CT 06851, Attn: HIPAA Contact

THIS SECTION IS TO BE COMPLETED BY C.A.P. 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