

Pediatric Center PC

126 Morgan Street
Stamford, CT 06905

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 Pediatric Center PC 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 Officer Contact
(203) 327-1055**

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

Patient(s) Name: _____

Signature: _____

Relationship to Patient: _____

(If signed by someone other than patient.)

Date

THIS SECTION IS TO BE COMPLETED BY PEDIATRIC CENTER PC 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:

Parent/Patient declined to sign this Written Acknowledgment.

Other (specify): _____

Name and title of employee

Date