ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
for
Farmington Pediatric & Adolescent Medicine, LLC

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that Farmington Pediatric & Adolescent Medicine, LLC has offered or provided me with a copy of its Notice of Privacy Practices, which 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:
Barbara Ziogas, M.D.
(860) 677-1112
I also understand that I am entitled to receive updates upon request if Farmington Pediatric & Adolescent Medicine, LLC amends or changes its Notice of Privacy Practices in a material way.

PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient

Everything below this line is for OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY *Farmington Pediatric and Adolescent Medicine, LLC* IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT 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(s), but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment

[ ] Other (specify): _____

_____ _____
Name and title of employee Date