

# 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 Willows Pediatric Group 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 Contact  
203-319-3939 ext. #1111**

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient, if signed by  
someone other than patient.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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

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- Given to above signee
- Sent home via U.S. Mail

*In either situation the parent/legal guardian is requested to sign and return to  
Willows Pediatric Group*

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## **THIS SECTION IS TO BE COMPLETED BY WILLOWS PEDIATRIC GROUP IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT**

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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