

# Acknowledgement of Receipt of Notice of Privacy Practices

Gary J. Price, M.D., 5 Durham Road, Suite 1 – 8, Guilford, CT 06437

Kathleen Bednarczyk, Patient Coordinator, Tel #:(203)-453-6635 X-305 of Privacy Officer

Name of Patient: \_\_\_\_\_

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_ 3/16/2010

Print Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_

## ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain: \_\_\_\_\_

Reasons for refusal: \_\_\_\_\_