**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 acknowledge that this medical clinic has provided me with the opportunity to have a copy of its Notice of Privacy Practices which is also posted on our website at [www.coppervalleymedical.com](http://www.coppervalleymedical.com), or otherwise made a copy available to me 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 the medical director.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS SECTION IS TO BE COMPLETED BY THE CONNECTICUT CENTER FOR HEALTH 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, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify):

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Name and title of employee Date