

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES EAR, NOSE AND THROAT CENTER, LLP 32 STRAWBERRY HILL CT - STAMFORD, CT 06902 TEL: (203) 353-0000 - FAX: (203) 357-8109

NAME OF PATIENT:
I HEREBY ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES. THE NOTICE OF PRIVACY PRACTICE PROVIDES DETAILED INFORMATION ABOUT HOW THE PRACTICE MAY USE AND DISCLOSE MY CONFIDENTIAL INFORMATION. I UNDERSTAND THE PRACTICE HAS RESERVED THE RIGHT TO CHANGE ITS PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE. I ALSO UNDERSTAND THAT A COPY OF ANY REVISED NOTICE WILL BE PROVIDED TO ME OR MADE AVAILABLE.
SIGNATURE OF PATIENT:
PRINT NAME:
TELEPHONE NUMBER:
DATE:
IF SIGNED BY SOMEONE OTHER THAN 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: