ACKNOWLEDGEMENT 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.

Name of Patient _____ **DOB** _____

I, _____ , hereby acknowledge that Litchfield County Pediatrics 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:

Practice Privacy Contact: Karen S. Dettmer, MD, 860-489-4144

I also understand that I am entitled to receive updates upon request if Litchfield County Pediatrics 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

If the above signature is obtained from someone other than the legally responsible individual, action taken to obtain legal signature will be:

[ ] Given to above signee to deliver to responsible individual
[ ] Sent home via U.S. Mail

In either situation the parent/legal guardian is requested to sign and return to:
Litchfield County Pediatrics, 20 Felicity Lane, Torrington, CT 06790

THIS SECTION IS TO BE COMPLETED BY LITCHFIELD COUNTY PEDIATRICS IF UNABLE TO OBTAIN WRITTEN ACKNOWLDGEMENT 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):_____

_____	_____
Name and title of employee	Date

Karen S. Dettmer, MD | Sophia Zervas Grant, MD | Richard T. Tenczar, MD | Michelle Henry, APRN
20 Felicity Lane, Torrington, CT 06790 | Phone: 860.489.4144 | Fax: 860.489.4412 | www.lcpediatrics.com