Acknowledgement of Receipt of Notice of Privacy Practices

Woodland Women's Health Associates
19 Woodland Street, Suite 31
Hartford, CT 06105

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy and that I may request a copy of any amended Notice of Privacy.

Signed: _____ Date: _____

Print Name: _____

If not signed by patient, please check below:

___ Parent ___ Legal Guardian ___ Conservator ___ Patient's Representative

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For office use only:

___ Acknowledgement refused:

Efforts to obtain: _____

_____

_____

Reasons for refusal: _____

_____

_____