Acknowledgement of Receipt of Notice of Privacy Practices

Taylor Associates

Obstetrics & Gynecology

499 Farmington Ave
Suite 220
Farmington, CT 06032

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 complete below:
Relationship to Patient: 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: _____
_____

Rev. for Taylor Associates 5/5/11 UAS & LTT
A division of Physicians for Women's Health