ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR ASSOC. PHYS. OF STHBY.

We are required by State and Federal laws, including HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become out patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any of it.

ACKNOWLEGMENT

I acknowledge that APS has offered or provided me with a copy of Privacy Practices, which describes how medical information about me may be used or disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Privacy Officer at 203-264-3319

I also understand that I am entitled to receive updates upon request if APS amends or changes its Notice of Privacy Practices in a material way.

X_____ X_____

Signature or patient /patient representative Date

X_____ _____

Printed name of patient/representative Relationship to patient

Everything below for office use ONLY

COMPLETE BY APS IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of Notice of Privacy Practices from above-named patient, but was unable to because:

( )Patient declined to sign this written acknowledgement

( )Other (specify)_____

_____ _____

Name and title of employee Date