Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information, according to federal and state law (often referred to as HIPAA). I encourage you to read it in full.

In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy from the Forms mailed to you by calling me at 860-849-6743.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this acknowledgement, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her guardian Date

_____ _____

Printed name of client or guardian Date

_____

Description of personal representative's authority

__ Copy of Privacy Practices given to the client/parent/personal representative