

Danbury Eye Physicians & Surgeons, P.C.

69 Sand Pit Road Danbury, CT 06810	203-791-2020
120 Park Lane, B203, New Milford, CT 06776	860-946-6000
166 Waterbury Road, Suite 201, Prospect, CT 06712	203-758-5733
215 Main Street, Westport, CT 06880	203-221-8600

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

We are required by State and Federal laws, including the 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 our 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 of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

I, _____, hereby acknowledge that I have been offered or have received a copy of Danbury Eye Physicians & Surgeons, P.C. Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Diane – Medical Records Manager
Danbury Eye Physicians & Surgeons, P.C.
69 Sand Pit Road
Danbury, CT 06810
Phone: 203-791-2020

I also understand that I am entitled to receive updates upon request if Danbury Eye Physicians & Surgeons, P.C. Notice of Privacy Practices is amended or changed in a material way. This authorization is signed by:

Signature of Patient or Patient's representative

Date:

Printed name of Patient or Patient's representative
Relationship to Patient: _____

Date:

Everything below this line is for OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY THE DANBURY EYE PHYSICIANS AND SURGEONS, PC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

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

☐ Patient declined to sign this Written Acknowledgment

☐ Other (specify): _____

Name and title of employee

Date

REV 02.17