

**Written Acknowledgement of Receipt
of Notice of Privacy Practices**

Patient Name: _____
Date of Birth: _____

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:
Jackie Hirsch, Privacy Officer
464-7248

I also understand that I am entitled to receive updates upon request if Gales Ferry Pediatrics' Notice of Privacy Practices is amended or changed in a material way.

Signature

Relationship to Patient

Date

**TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN
ACKNOWLEDGEMENT FROM PATIENT.**

On _____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgement.
- Patient did not understand the request to sign the Written Acknowledgement.
- Other [specify]: _____

Name and title of employee.

Date

Request for Confidential Communications

Patient Name

Date of Birth

I hereby request that any communications made by Gales Ferry Pediatrics to me be made:

- phone home/work number answering machine
 mail address other

May we speak with parents children other family members other _____

I give permission for information to be left on my answering machine:

- test results appointments with other doctors appointments for tests

reminder calls for appointments information regarding prescriptions other _____

I would like all future communications to me to be made in accordance with my wishes as expressed above. I understand that if I refuse to specify an alternate address or to provide information as to how payment, if any, will be handled, Gales Ferry Pediatrics may deny my request.

Signature of Patient or Personal Representative

Relationship to Patient

Date