Dermatology Associates of Eastern Connecticut, LLC

Acknowledgement of Receipt of Privacy Practices

Patricia Zambrello, Practice Manager, the Privacy Officer

Name of Patient: _____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Print Name: _____ Date: _____

Signed: _____

(If not signed by the patient, please indicate your relationship to the patient.)

_____

For Office Use Only

Signed form received by:

_____

Acknowledgement refused:

Efforts to Obtain:

_____

_____

Reasons for Refusal:

_____

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