## CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C. DANA K. CIPRIANO, PRACTICE ADMINISTRATOR (203) 574-3777 Ext. 121

## **Acknowledgment of Receipt of Notice of Privacy Practices**

Nam	e of Patient:				
Practi	eby acknowledge that I relices. I further acknowledest a copy of any amende	ge that a copy of the	current noti	ce is posted in the recep	ice's Notice of Privacy ption area, and that I may
Signed:			Date:		
Print	Name:			Telephone:	
If not	signed by the patient, pl	ease indicate your re	elationship to	the patient:	
****	*******	******	*****	*******	********
	PATIENT RECORD	OF DISCLOSUR	E OF PROT	ECTED HEALTH IN	NFORMATION LOG
I wis	h to be contacted in the	following manner	for my appo	Cell Pho	lumberone
	Work Number				
***	CONNECTICUT One Exchange	EAR, NOSE & TI Place Building, 3 <sup>rd</sup>	HROAT, SIN Floor, 21 We	NUS & ALLERGY SE est Main Street, Waterb ase Disclosure and/or	oury, CT 06702
to me	embers of your immediat	e family, spouse, gu	ardian or any	other person(s) that yo	ent and health care operations ou identify who are involved hals of your location, general
	Print patient's name		Date of Birth		Today's date
	I do want my health in I do <u>not</u> want my healtl			U	
Name		Relationship		Address	Phone No.
	**************************************				************
	Acknowledgment refused:	Employee	signature	2	
	Efforts to obtain:			Reasons for refusal:	
					Rev. 4/06