

**BLOOMFIELD FOOT SPECIALISTS, LLC
1 NORTHWESTERN DRIVE, SUITE 301
BLOOMFIELD, CT 06002**

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I reviewed 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 it may be amended at any time, and I may request a copy of the Notice of Privacy Practices at any time.

I understand that if I have questions or complaints, I may contact the Privacy Officer at (860) 243-2951.

Notice to Allow Office to call and leave a detailed messages, circle YES or NO

Home: **YES / NO** Phone # _____

Office: **YES / NO** Phone # _____

Cell: **YES / NO** Phone # _____

List of Individuals we are allowed to discuss your care with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**** I understand that it is my responsibility to notify the office of ANY changes in my calling information or HIPAA information. ****

Signature: _____ Date: _____

****If not signed by patient, please indicate relationship to patient:**
