BLOOMFIELD FOOT SPECIALISTS, LLC
705 BLOOMFIELD AVENUE, SUITE 201
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:**

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REV6/21