Acknowledgement of Receipt of Notice of Privacy Practices

Shoreline Surgical Associates
400 Saybrook Road Suite 110
Middletown, CT 06457
(860) 347-9167

Name of Patient: _____

I hereby acknowledge that I 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.

I authorize Shoreline Surgical Associates to release any and all information of my healthcare to the following: (family, significant other, etc.)

Name:	Relationship:	Phone Number:

{ } I do not wish to have information released.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

D.O.B. _____

If not signed by the patient, please indicate your relationship to the patient: _____

***For Office Use Only*:**

- Signed form received by: _____
- Acknowledgment refused:

  Efforts to obtain:

  _____

  _____

  Reasons for refusal:

  _____

  _____