ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIGH RIDGE FAMILY PRACTICE
30 BUXTON FARMS ROAD, SUITE 210, STAMFORD, CT.

ALAN T FALKOFF, MD, SENIOR MEDICAL PARTNER, OFFICE MANAGER, SECURITY OFFICER
203-322-7070

Name of Patient:_____

I hereby acknowledge that I have reviewed a copy of this medical practice's Notice of Privacy Practices. I understand that I may request a copy of this notice and any amended Notice of Privacy Practices in the future.

Signed:_____Date:_____

Print Name:_____Telephone:_____

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:_____