



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient’s medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Copper Valley Medical, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Don Selvey, NMD, PLLC
Medical Director
602-566-2015

I also understand that I am entitled to receive updates upon request if Copper Valley Medical, LLC amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if signed by someone other than patient.

Date

THIS SECTION IS TO BE COMPLETED BY THE CONNECTICUT CENTER FOR HEALTH IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgment.

Other (specify):

Name and title of employee

Date