ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

Section 1:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ __________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

***Section 2*:(optional)**

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Please complete Section 2 if there is a specific party to which you would like your medical care and financial account disclosed to. Please do **not** include your Insurance Company or Primary Care Physician.

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I authorize Connecticut Foot Care Centers, L.L.C. to discuss all aspects of my medical care and financial account with ____.
I understand that I may revoke this authorization at any time by notifying Connecticut Foot Care in writing.

____ __________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature