ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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 understand the Notice.

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable)

_____

Signature

_____

Date

Associated Podiatrists
Podiatry & Foot Surgery

Fairfield

1881 Post Road
Fairfield, CT 06824
203-255-1036

North Haven

83 Washington Avenue
North Haven, CT 06473
203-787-3800

Greenwich

282 Railroad Avenue
Greenwich, CT 06830
203-869-2022