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 East West Integrative Health Clinic, 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:

East West Integrative Health Clinic, LLC
(203) 915 - 9125

I also understand that I am entitled to receive updates upon request if East West Integrative Health Clinic, 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 EAST WEST INTEGRATIVE HEALTH CLINIC, LLC **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