

Natural Pediatric Medicine, LLC – Dr. Robin Russell
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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Dr. Robin Russell’s Notice of Privacy Practices detailing how my health information may be used and disclosed under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information:

Patient’s Name: _____

DOB: _____

Patient’s Signature OR (Authorized Representative)

Date

FOR OFFICE USE ONLY

- Patient refused to sign Acknowledgement of Receipt of Privacy Practices
- Patient was unable to sign Acknowledgement of Receipt of Privacy Practices due to reasons specified below.

Provider Signature

Date