

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

HIGH RIDGE FAMILY PRACTICE
30 BUXTON FARMS ROAD, SUITE 210, STAMFORD, CT.

ALAN T FALKOFF, MD, SENIOR MEDICAL PARTNER, OFFICE MANAGER,
SECURITY OFFICER
203-322-7070

Name of Patient: _____

I hereby acknowledge that I have reviewed a copy of this medical practice's Notice of Privacy Practices. I understand that I may request a copy of this notice and any amended Notice of Privacy Practices in the future.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: _____

Efforts to obtain: _____

Reasons for refusal: _____