# ARRHYTHMIA CONSULTANTS OF CONNECTICUT, LLC

## WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name

Medical Record # Date of Birth

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

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|---|---|
| Patient Signature: | Date: |
| or Signature of Patient's Representative: | Date: |

**FOR OFFICE USE ONLY**

To be completed by practice if unable to obtain written acknowledgement from the patient:

- ☐ Patient refused or declined to sign this written acknowledgement
- ☐ Patient could not understand request to sign written acknowledgement
- ☐ Other reason: (please specify):

| | |
|---|---|
| Employee Signature: | Date: |
| Employee Title: | |

Notes: