



HIPPA PRIVACY NOTICE RECEIPT FORM

I, (Patient's Name) _____ on (Date)_____

acknowledge that Caring for Fertility LLC has provided me with a copy of its Notice of Privacy Practices. I understand that if I have questions or complaints I may contact:

Caring for Fertility LLC
597 Farmington Ave
Hartford, CT 06105

Patient's Signature _____

If minor, parent/guardian _____

Witness Signature _____