ACKNOWLEDGEMENT OF RECEIPT
"NOTICE OF PRIVACY PRACTICES"

I hereby acknowledge that I have received a copy of the following material:

"Notice of Privacy Practices – Laurel Ridge Surgical Associates, version 1"

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Date

____

Printed Name of Patient and Signature of Patient (or parent of minor; guardian; POA)

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Signature of Witness

If this patient refuses or is unable to sign, fill out the following:

Name of Patient:________________

Name of Employee completing form:___________________

Date:_________________

Reason:

Designation of Contact Person or Next of Kin

Please designate the person or persons who may receive information about your condition or whom we may contact in an emergency:

Name: ________________________________

Phone: ________________________________

Relationship: ________________________________

Form # 104