Acknowledgement of Receipt of Notice

Patient Name ____ Date _________________________

I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices was made available to me by Montrose Surgical Associates.

I understand that I may request a revised copy of this medical practice's Notice of Privacy Practices at any time should there be any subsequent changes.

Signed: ____ Date: __________________________

Print Name: ____ Telephone: _____________________

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or Guardian of minor patient
- ☐ Guardian or Conservator of an incompetent patient
- ☐ Beneficiary or Personal Representative of deceased patient

Name of Patient: ____

***For Office Use Only*:**

Signed form received by: ___________________________

Acknowledgment refused:

Efforts to obtain:

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Reasons for refusal:

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