

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Dayton Surgeons Inc.'s Notice of Privacy Practices.

Signature of patient or personal representative

Date

If signed by personal representative, relationship to patient

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient Name: _____

Refused to Sign Physically unable to Sign

(Other)

Employee Signature _____ Date: _____