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Over 75 Years of Experience treating Brain & Spine disorders

Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ___________________________________ Chart #: ___________________

I, _________________________________, hereby acknowledge that I have had the opportunity to receive a copy of the Notice of Privacy Practices and have access to the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Joan Monroe, HIPPA Privacy Officer
Neurosurgical Associates of SW CT, PC
67 Sand Pit Road, Suite 208
(203) 792-2003

I understand that I am entitled to receive updates upon request if the Notice of Privacy Practices is amended or changed in a material way.

____________________________________ ____________________________________
Signature Relationship To Patient

____
Date

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

On, ______________________, I attempted to obtain a Written Acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

- ☐ Patient declined to sign this Written Acknowledgement
- ☐ Patient did not understand the request to sign the Written Acknowledgement
- ☐ Other (Specify): ____

Employee Name: ___________________________________ Date: ___________________