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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN AKNOWLEDGMENT FORM

I have received a copy of CJ Specialty Surgical Associates, LLC's Notice of Privacy Practices

_____ _____
Name of Patient (please print) Date

_____
Signature of Patient

_____ _____
Signature of Guardian if patient under 18 y/o Relationship to Patient

DISCLOSURES TO FAMILY, FRIENDS OR OTHERS.

Please indicate if we may provide your PHI to a family member, friend, or other person that is involved in your care.

Yes, I _____ authorize the disclosure of my medical records to:

_____
Indicate name and relationship

No ___ I don't authorize the disclosure of my medical records

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

_____ _____
Date *Initials*

Reason: _____