

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practices of LIBERTY SURGICAL ASSOICATES, PLLC. I further acknowledge that I have had an opportunity to ask questions about this policy.

Name _____

Signature _____ Date _____

If this acknowledgement is not signed by the patient, please sign below.

Name of person signing _____

Signature _____ Date _____

Witness _____

Contact Instructions for LIBERTY SURGICAL ASSOCIATES

****please initialize one of the below options**

_____ I authorize the physicians and staff of LIBERTY SURGICAL ASSOCIATES to communicate any and all aspects of my medical care including (but not limited to) scheduled appointments, lab results, x-ray results, and financial information to the individuals listed below or left on the message machine.

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

I can be contacted at the following phone numbers: home: _____

cell: _____

work: _____

_____ I **DO NOT** want any information regarding my medical care left on my message machine or given to any person except myself.

Revised: 7/09/09