



**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

(Please Check One)

I, _____, have received a copy of The Kansas City Neurosurgery Group's Notice of Privacy Practices.

I, _____, refuse to accept a copy of The Kansas City Neurosurgery Group's Notice of Privacy Practices.

Patient Signature

Date

It is OK to leave a detailed message at: Home Work Cell Phone

Information may be discussed with the following individuals:

<u>Name:</u>	<u>Relationship:</u>	<u>Medical</u>	<u>Financial</u>	<u>Both</u>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature or Designee
Parent/Guardian if patient is a minor

Date

Two witnesses are required if designee is signing form:

Witness

Witness