LANCASTER
NEUROSCIENCE
& SPINE ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I received Lancaster NeuroScience & Spine Associates' and The Center for Spine Care's Notice of Privacy Practices.

_____
Name of patient

_____ _____
Signature of patient (or patient's personal representative) Date of receipt

_____
Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

_____
Name of patient:

_____
Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)

I provided the above named patient personal representative (check one) with Lancaster NeuroScience & Spine Associates' and The Center For Spine Care's Notice of Privacy Practices for Protected Health Information.

Describe how notice was provided:
_____ Offered copy and individual refused to accept delivery
_____ Offered copy and individual accepted delivery
_____ Other_____

Describe efforts to obtain signature on Acknowledge of Notice form:
_____ Patient/personal representative was asked to sign form and refused.
_____ Other_____

_____
Signature Date

_____
Printed Name