

Acknowledgement of Receipt of Notice of Privacy Practices

Capital Neurological Surgeons

A Medical Corporation

Privacy Officer: Cynthia Griswold, Practice Administrator

(916) 453-0911

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- Parent or Guardian of a Minor Patient
- Guardian or Conservator of an Incompetent Patient
- Beneficiary or Personal Representative of a Deceased Patient

Name of Patient: _____