



cardiothoracic  
surgery group

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices. If you have any questions, do not hesitate to contact us at 1-800-508-0885 and ask for Sue K.

X \_\_\_\_\_

Signature of patient or personal representative

\_\_\_\_\_

If signed by personal representative, relationship to patient

\_\_\_\_\_

Date

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Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Refused to Sign

Physically unable to Sign

(Other) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

