ALPINE SURGICAL
Dedication Above and Beyond.

Anderson Medical Center
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address:_____

Practice Name: Alpine Surgical

I have been given a copy of Alpine Surgical's *Notice of Privacy Practices*, which describes how my health information is used and shared. I understand that Alpine Surgical has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Alpine Surgical web site at www.alpinesurgical.net.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Practice Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

Completed by:

_____ _____
Signature of Practice Representative Date

_____
Print Name