THE UROLOGICAL CENTER/ANTIETAM UROSURGICAL CENTER
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of The Urological Center/Antietam UroSurgical Center (the "Center") Notice of Privacy Practices.

_____

Signature of Patient or Patient's Authorized Representative

_____

Print Name of Patient

_____

Date

As the Patient's Authorized Representative, my relationship with the patient is:

_____

The Patient is unable to sign because:

_____

----------OR----------

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

_____ I hereby certify that, as an associate or agent of the Center, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgement of the Center's Notice of Privacy Practices in accordance with the Center's Administration policy "Notice of Privacy Practice Requirements."

_____

Print Name of Associate/Agent, Position and Department

_____

Signature of Associate/Agent

_____

Date

Reason(s) for not obtaining acknowledgement:

_____ Patient's medical condition (critical, unconscious, etc.)
_____ Language barrier
_____ Patient refuses to sign (reason stated:

_____