Acknowledgement of Receipt of Notice of Privacy Practices

Cardiac Surgery Associates reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Cardiac Surgery Associates.

____
Name of Patient (print please)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient