Center for Neurosurgical and Spinal Disorders

1614 Wolf Circle
Lake Charles, LA 70605
Telephone (337) 478-9653 • Fax (337) 474-0988

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ……...……..

Printed Name of Individual or Legal Representative …….……...

Witness…….

Date: ……

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify)

_____
_____
_____

_____ _____

HIPAA Officer Date