

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

(Version effective: 4/14/ 2003)

**Patient Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_

I, \_\_\_\_\_, hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

**Greenwich Neurosurgery  
25 Valley Drive  
Greenwich, CT 06831  
203-661-3333  
Attn:Michelle McDermott-Privacy Officer**

I also understand that I am entitled to receive updates upon request if Greenwich Neurosurgery's Notice of Privacy Practices is amended or changed in a material way.

**Signature:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**TO BE COMPLETED BY GREENWICH NEUROSURGERY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.**

On \_\_\_\_\_, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgement.
- Patient did not understand the request to sign the Written Acknowledgement.
- Other (specify)\_\_\_\_\_

**PRIVACY QUESTIONS:**

**Patient Name:** \_\_\_\_\_

**We are authorized to discuss your medical condition with the following: (Please list all family members/work associates/etc. that we can communicate with)**

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**We can leave a message on your answering machine confirming your appointment with Greenwich Neurosurgery or we can leave a message with details of an upcoming test and or results of test. Yes \_\_\_\_\_ or No \_\_\_\_\_**

**Our billing office may discuss your bill with:( Please list all family members/work associates/etc. that we can communicate with)**

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**We can send information related to medical care (that may be of interest to you). Yes \_\_\_\_\_ or No \_\_\_\_\_**