Methodist MANSFIELD AMBULATORY SURGERY CENTER

# NOTICE OF PRIVACY PRACTICES

## ACKNOWLEDGEMENT OF RECEIPT

I,_____, acknowledge that I have received a copy of the Notice of Privacy Practices of Methodist Mansfield Ambulatory Surgery Center.

_____ _____

Patient Signature Date

If completed by a patient's personal representative, please print and sign your name in the space below:

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

**For Center use only**

Complete this section if this form is not signed and dated by the patient or patient's representative

**I have made a good faith effort to obtain a written acknowledgement of receipt of Methodist Mansfield Ambulatory Surgery Center Notice of Privacy Practices but was unable to for the following reason:**

- ☐ Patient Refused to sign
- ☐ Patient Unable to sign

_____ _____

Employee Name Date

Patient Label