Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of HOUSER NEWMAN ASSOCIATES, MAHONING VALLEY AMBULATORY SURGERY CENTER, and LEHIGH ANESTHESIA ASSOCIATES **Notice of Privacy Policies**. My information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I will allow the following persons to receive my personal medical information:

Name:_________________________________ Relationship to Patient:__________________

Name:_________________________________ Relationship to Patient:__________________

Name:_________________________________ Relationship to Patient:__________________

Name:_________________________________ Relationship to Patient:__________________

Name:_________________________________ Relationship to Patient:__________________

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefit apply.

Patient Name:______________________________________ DOB:________________________

Patient Signature: __________________________________ Date: ______________________

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____________________ Witnessed by: ________________________________

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____________________ By: ____

(date/time) (name/title)

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