

**ST. CHARLES ORTHOPAEDIC SURGERY ASSOCIATES, INC.**  
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**EFFECTIVE DATE: APRIL 14, 2003**

Name of Patient: \_\_\_\_\_

Do you authorize us to release any information to any other person or persons (spouse, parent, friend, child)?  
No information, such as test results or appointment changes, can be given to any other person unless listed.

List name and relation:

	Name	Relation to patient
1.	_____	_____
2.	_____	_____
3.	_____	_____

May we leave a detailed message regarding test results or other information on your voice mail? Yes No

If your disability insurance carrier requests information about you, either verbally or in writing may we provide requested information? Yes No

***I hereby acknowledge that I have received the St. Charles Orthopaedic Surgery Associates Inc. ("SCOSA") Notice of Privacy Practices***

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

*If Personal Representative's signature appears above, please describe relationship to the Patient:*

\_\_\_\_\_

**(FOR COMPLETION BY SCOSA)**  
**DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT**

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

*The Patient presented for service on the date set forth above and was provided with a copy of SCOSA's Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained for the following reason(s):*

\_\_\_\_\_ *Patient refused to sign acknowledgement.*

\_\_\_\_\_ *Patient was unable to sign the acknowledgement because:* \_\_\_\_\_

\_\_\_\_\_ *Other reason:* \_\_\_\_\_

*Name of Employee Completing Form:* \_\_\_\_\_

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