



CHICAGO INSTITUTE OF
NEUROSURGERY AND NEURORESEARCH



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I have been told that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 773.250.0500 or by requesting one at this office.

(Date)

(Signature*)

(Print or Type Name)

* As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

(Signature)

(Relationship)

(Date)