Patient: _____ _____ _____ _____

Last Name First Name M.I. Date of Birth

UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA, LTD.

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health care, the care that you receive, or payment for that care is considered confidential and protected by our Company. We may need to use your protected health information to carry out treatment, payment, healthcare operations and other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. (Copy provided upon request)

_____ _____

Signature of patient or patient's representative **Date**

Printed name of patient or patient's representative_____

Relationship to the patient: _____

For use ONLY by a representative of the Company

A good faith effort was made to obtain a written acknowledgement for receipt of our Notice of Privacy Practices was made available to (circle one) the patient/the patient's representative on:

A signature on the acknowledgement was not obtained for the following reason(s)

Signature of Company representative_____