



# WRITTEN ACKNOWLEDGEMENT

Our **Notice of Privacy Practices** provides information about how we may use and disclose medical information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

I, (please print the patient 's name) \_\_\_\_\_  
have received a copy of the SURGICAL ASSOCIATES OF RICHMOND of **Notice of Privacy Practices**.

I have had an opportunity to read the **Notice of Privacy Practices**.

I understand that I may ask questions to SURGICAL ASSOCIATES OF RICHMOND, if I do not understand any information contained in the **Notice of Privacy Practices**.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

-OR-

\_\_\_\_\_  
Authorized Representative of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date