MAYFIELD Acknowledgment of Receipt of Notice of Privacy Practices

I, (print name) ______________________________ have been presented a copy of Mayfield Brain & Spine's Notice of Privacy Practices, detailing how my health information may be used and disclosed under federal and state laws.

Patient Signature ____ Date ______/______/______

Please mail completed form to:
Mayfield Brain & Spine, Attn: Initial Care Department, PO Box 19964, Cincinnati, OH 45219.
Call 513-221-1100 or 800-325-7787 if you need addresses for appointments or film drop off.

If you are signing as a legal representative for an individual, read and complete the form below:

I, ___________________________, hereby certify and attest that I am the duly authorized legal representative of ____________________________ and that I have the lawful authority regarding the use and/or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature ____ Date ______/______/______

Print Name ____

FOR INTERNAL USE ONLY

Name ___________________________________

MRN ___________________________________

If, after good faith efforts, written acknowledgment has not been obtained, document below the good faith efforts which were used to obtain such acknowledgment and the reason why the acknowledgment was not obtained (give dates and times as appropriate).

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Name ____ Title ___________________________________

Date ______/______/______