

**RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

Your signature on this consent will allow us to release information to, and receive information from, other healthcare providers for continuation of your healthcare. It will also allow you access to your own records from our facility without signing another consent. Your signature allows us to send your information via mail, fax, or electronically.

I have received a copy of Midwest Neurosurgery's Notice of Privacy Practices which are effective April 14, 2003.

Date

Printed Name

Signature

Note: If signed by someone other than the patient, we need written proof of your authority.