MIDWEST NEUROSURGERY ASSOCIATES, P.C.
6420 Prospect, Suite T411
Kansas City, MO 64132-1189

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessment and physician certifications.**

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient (or Custodian) Name: ____ Date:______________

Signature:____ Relation to Patient:_________________

In accordance with *Midwest Neurosurgery Associates Privacy Practices,* I hereby authorize Midwest Neurosurgery Associates to communicate with my spouse, children, and/or parents regarding my care and I authorize representatives of MWNS to communicate with me via home answering machine , voice mail (work phone or cell phone), and/or E-mail unless I check this box: □

I hereby authorize Midwest Neurosurgery Associates to communicate with the following people:

Name	**Relationship**
_______________________________________	____
_______________________________________	____

These authorizations will remain in effect until you send us written notice of your desire to revoke the authorizations.

Signature:____ Date:_______________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	**Initials:**
Reason:	

Hipaa02-24-10