SOUTHWEST NEUROSURGICAL ASSOCIATES
Surgical Care of the Brain and Spine
8080 Academy Rd NE, Suite B – Albuquerque, NM 87111
TEL: 505.244.0080 – FAX: 505.244.9048 – WEB: www.swnsa.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of Southwest Neurosurgical Associates Notice of Privacy Practices.

_____

Patient or legally authorized individual signature Date

_____

Printed Name if signed on behalf of the patient
Relationship (parent, legal guardian, personal representative, etc.)

I authorize and agree that Southwest Neurosurgical Associates (SWNSA) may disclose my protected health information to the following persons:

1. _____
2. _____
3. _____
4. _____

I acknowledge and agree that SWNSA may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to SWNSA.

_____

Patient or legally authorized individual signature Date

_____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian personal representative, etc.)

For Office Use Only

Date Acknowledgement received: _____

Signature of SWNSA Employee: _____

-Or-

Reason Acknowledgement was not obtained (declined to sign): _____

_____