ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the *The Spine & Brain Institute's* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *The Spine & Brain Institute* and how I may obtain access to and control this information.

_____ _____

Signature of Patients or Personal Representative Date

_____ _____

Signature of Patients or Personal Representative Date

COMPLETE SECTION BELOW IF WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

_____The individual refuses to sign or otherwise fails to provide an acknowledgement

_____The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

_____ _____

The Spine & Brain Institute Representative Signature Date