

ACKNOWLEDGEMENT OF RECEIPT

SOUTH FLORIDA CARDIOVASCULAR SURGICAL ASSOCIATES, P.A. NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of South Florida Cardiovascular Surgical Associates, P.A.' s Notice of Privacy Practices.

Patient's Printed Name

Patient's Signature

Date

FOR SOUTH FLORIDA CARDIOVASCULAR SURGICAL ASSOCIATES, P.A. USE ONLY

Date Acknowledgement Received ____/____/____

Reason acknowledgement was not obtained: _____