



Acknowledgment of Receipt of Privacy Practices Notice

I understand that Metropolitan Urological Specialists, P.C. consists of a group of healthcare providers and these providers may share my health information for treatment, payment and other healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Metropolitan Urological Specialists, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting any of the doctor's offices or by visiting the web site at www.metrourology.net.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

_____	_____
Printed Name of Patient	Date of Birth
_____	_____
Signature of Patient or Legal Representative	Date

If signed by legal representative, relationship to patient: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify):

