# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## Medical Surgical Wellness Center, LLC

By signing below, I _________________ acknowledge that I
(please print name here)
have received the **Notice of Privacy Practices** from Medical Surgical Wellness Center, LLC

__________________________ __________________
Signature Date

If not signed by patient, please indicate your relationship to the patient.

Relationship: __________________________ Witnessed by:__________________

I am also giving my permission for my medical information to be released and discussed with the following people:

1. ______________________________________ Relationship:__________________
2. ______________________________________ Relationship:__________________
3. ______________________________________ Relationship:__________________