CHICAGO INSTITUTE OF
NEUROSURGERY AND NEURORESEARCH

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I have been told that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling __773.250.0500__ or by requesting one at this office.

________________________	________________________
(Date)	(Signature*)
	________________________
	(Print or Type Name)

* As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

________________________	________________________
(Signature)	(Relationship)
	________________________
	(Date)

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