

Tri-County Surgical Associates, P.A.
General Surgery

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**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES**

I, _____, hereby acknowledge that I have reviewed/received a copy of the Tri-County Surgical Associates, P.A., **Notice of Privacy Practices**, and statement of **Office Policies**. The **Notice of Privacy Practices** details how my information may be used and disclosed as permitted under Federal and State law.

I understand the content of these documents and I request the following restriction(s) concerning the use of my personal medical information.

Signature of Patient or Patient's Representative

Description of Representative's Authority

Date