TOWN CENTER
AMBULATORY SURGERY CENTER

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of **Town Center ASC, LLC** Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: ____/____/____

Patient: _____ Date: ____/____/____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

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For Office Use Only

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Patient/Representative Unable to Sign – Notice of Privacy Provided _____

Patient/Representative Refused to Sign – Notice of Privacy Provided ____

Other _____

Signature: _____ Date: ____/____/____

Print Name: _____ Date: ____/____/____