MNH Surgical Center

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

MNH Surgical Center reserves the right to modify the privacy practices outlined in this notice .

Signature :

I have received a copy of the Notice of Privacy Practices

_____
Patient Name (Print)

_____ _____
Patient Signature Date

_____ _____
Guardian (if not the patient) Relationship

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- ☐ I give permission to MNH Surgical center nursing staff to communicate my discharge instructions and other medical information regarding my procedure to:
  _____ ☐ Spouse ☐ Friend ☐ Other _____
  Name of person

- ☐ I do not wish to have my medical information or discharge instructions be released to anyone but me.