

OZARK SURGICAL GROUP

GENERAL, THORACIC AND VASCULAR SURGERY

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Receipt of Notice of Privacy Practices Written Acknowledgment

I _____ have received a copy of the
(Patient Name)

Notice of Privacy Practices of Ozark Surgical Group.

We will share your medical information with your referring physician and any physician(s) to whom we refer you.

We will not discuss your care or provide medical information to anyone outside the medical community without your permission.

Please list all individuals with whom we may discuss your care. (i.e. spouse, children, sister, brother, mother, father, grandmother, neighbor, friend, clergy.)

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____
_____	_____
_____	_____
_____	_____

Date _____

Patient Signature

Chart Number _____

Excellence in Surgical Care