NeuroCare Institute of Central Florida, P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I hereby acknowledge receipt of the NeuroCare Institute of Central Florida, P.A. Notice of Privacy Practices.

Name (Please Print)____

Signature: ____

Date: ____________________________

OR

I am a parent or legal guardian of ____ [patient name].

I hereby acknowledge receipt of the NeuroCare Institute of Central Florida Notice of Privacy Practices with respect to the patient.

Name [please print]: ____

Relationship to Patient (Circle One): Parent Legal Guardian

Signature: ____

Date: ____