

**Newton Wellesley Surgeons**

**ACKNOWLEDGEMENT  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge the receipt of *Newton Wellesley Surgeons* **Notice of Privacy Practices** which provides me with detailed information about how the office may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I also understand that if they amend its **Notice of Privacy Practices**, I will be informed of the change and may obtain a copy of the revised Notice by calling the office at (617) 244-5355 or on the practice website [www.nwsurgeons.com](http://www.nwsurgeons.com).

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
(please print)

Date of Birth \_\_\_\_\_