Neurosurgical Specialists, Inc.
580 E. Main Street, Suite 200
Norfolk, VA 23510

Acknowledgement of Receipt of Privacy Notice & Red Flag Rule

I have been presented with a copy of Neurosurgical Specialists, Inc.'s Notice of Privacy Policies (HIPAA) & the Red Flag Rule, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following people permission/restriction concerning the use of my personal medical information:

Person's ***permitted*** to request medical information:	Person's ***restricted*** from requesting my medical information:
____________________	____________________
____________________	____________________
____________________	____________________

Signed: ____________________ Date: ____________________

If not signed by patient, please indicate relationship to patient.
Relationship: ____________________

Witnessed By: ____________________

RED FLAG RULES
Patient Password: ____________________

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: Date: ____________________ Time: ____________________

Employee Signature: ______________________