



**ALLIED UROLOGICAL SERVICES, LLC**  
Metropolitan Lithotripter Associates, PC

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print Patient's name) \_\_\_\_\_, acknowledge and agree that I have received a copy of Metropolitan Lithotripter Associates' Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Patient Legal Representative (if applicable) Date

\_\_\_\_\_  
Print Name of Legal Representative Relationship to Patient

**FOR FACILITY USE ONLY:**

Metropolitan Lithotripter Associates, P.C. made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Signature of Staff Member Date