



METROPOLITAN LITHOTRIPTOR ASSOCIATES, PC
Allied Urological Services, LLC

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