

**HCA Physician Services
Mainland Surgical Associates
6807 Emmett F Lowry Expressway, Ste 101
Texas City TX, 77591
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I _____, have read and/or received a copy of Mainland Surgical Associates Notice of Privacy Practices.

Signature of Patient

Date

I _____, give permission for Mainland Surgical Associates to discuss anything regarding my medical care with the following person(s):

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

-OR

Please contact only me, personally, to discuss my care. In addition, I give permission for Mainland Surgical Associates to call me or leave a message for me for the purpose of notification of laboratory results or reminder of appointments at the following number(s):

_____ Home Phone Number _____

_____ Work Phone Number _____

_____ Cell Phone Number _____

_____ Emergency Contact Number _____

Print Name

Signature

Date