HCA Physician Services
Mainland Surgical Associates
6807 Emmett F. Lowry Expressway, Suite 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 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**