

PLEASE READ THE ENCLOSED CNS NOTICE OF PRIVACY POLICY THEN SIGN THIS ACKNOWLEDGEMENT OF PRIVACY NOTICE IN TWO PLACES, DATE AND CHECK ALL BOXES THAT APPLY. Return via mail to CNS Medical Group, PC., 3425 S. Clarkson St., Englewood, CO 80113 or fax to (303) 789-8470.

ACKNOWLEDGEMENT OF PRIVACY NOTICE
Effective 4/13/03

I acknowledge receipt of CNS Medical Group, PC Notice of Privacy Practices.

Patient's Name

Patient's Signature

-OR-

Parent/Spouse/Guardian
(For Patient's Unable to Sign)

Date

-OR-

Signer's Name

CONTACT PERMISSION
CNS Medical Group, PC has my permission to communicate with me as follows:

CHECK ALL BOXES THAT APPLY

- Must speak only with me.
- May leave message on my answering machine.
- May leave phone message with responsible adult.
- May send mail to my home.
- _____
Other Directions

Patient's Name

Patient's Signature

-OR-

Parent/Spouse/Guardian
(For Patient's Unable to Sign)

Date

-OR-

Signer's Name