ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices of Midtown Foot Clinic, P.C. & Midtown Surgical Center, LLC and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________	______________________
Name of Patient	Date of Birth
X______________________________	______________________
Signature of Patient or Authorized Person	**Date**