

**Acknowledgment of Receipt of Tyler Neurosurgical Associates, P.A. (“TNA”)
Notice of Privacy Practices (“Notice”)**

This office will not release any information other than under those circumstances described above, unless disclosure is required by law, a court, a legal process or governmental agencies.

Any complaints you may have pertaining to the security of your information should be directed to this office.

I have read the above Notice and have had any questions answered by TNA. I understand that by signing this form, I consent to the sharing of information as stated in this Notice. My consent is freely given. I understand that I may revoke this consent at any time if the revocation is in writing, but any disclosure given prior are permissible.

Patient’s Name (printed)

Date

Patient’s Signature (or guardian, if minor)

Date