OMAR TURK, MD

Neurologist- Board Certified

NEUROSLEEP CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative ("Agent") of the patient acknowledges that he or she personally received a copy of the **Neurosleep Center's** Notice of Privacy Practices on the date indicated below.

Print Name (Last, First): _____ M _____

Signature: _____ Date: _____

Information about Agent (Please list/attach appropriate documentation):

Agent's Name: _____

Title: _____

Documentation Provided: _____

_____

_____

The patient or legally authorized repetitive ("Agent") named above received a copy of the **Neurosleep Center** Notice of Privacy Practices but refused to sign.

Physician: _____ Date: _____

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