mississippibreastcenter.com
PHILLIP B. LEY, MD, FACS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from
(Print Patient Name)

Surgical Clinic Associates, P.A.

X_____Date:_____
(Patient Signature)

In lieu of patient signature I, _____, a staff member of Surgical Clinic Associates, P.A., state that _____ has been given our current Notice of Privacy Practices.

X_____Date:_____