
Urology Associates

Of Battle Creek, P.C.
4441 Capital Ave., S.W.
Battle Creek, MI 49015

269.788.6888 Telephone
269.788.6889 Facsimile

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN
ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of Urology Associates' Notice of Privacy Practices.
Patient Name

Patient Signature or Legal Guardian (if patient is a minor)

Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____, Urology Associates presented this Acknowledgement of Notice of Privacy Practices to
_____ (the patient). The patient refused to provide a signature when requested.

Witness

Date