I hereby acknowledge that I have been informed of John Lawson Surgical Group's Notice of Privacy Practices. If you wish to receive a copy of the Privacy Practices please notify a receptionist.

Signature _____

Date _____

Name of Patient _____

Employee Witness _____

I hereby authorize the following persons to receive my healthcare information:

1. _____
2. _____
3. _____
4. _____
5. _____

Signature _____

Date _____