

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (Form 100)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and care among multiple healthcare providers.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Surgical Associates, P.C. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

As provided for by HIPAA, and as described in the *Notice of Privacy Practices*, Surgical Associates, P.C. may use or disclose my health information for treatment, payment or healthcare operations. Therefore, unless I specifically object, Surgical Associates, P.C. may disclose to a member of my family, a relative, a close friend, caregiver or any other person I identify, my personal information that directly relates to that person's involvement in my care.

*Please list those individuals below that you would wish to use as **Contacts** to discuss your care as needed:*

Contacts: (List by name)

- Spouse _____ Mother _____
- Father _____
- Adult Children _____
- Other _____
- Other _____
- Other _____

Printed Patient Name

X _____
Signature

Date

Relationship if other than patient signature

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____

Date: _____

By: _____