NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A **Notice of Privacy Practices** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

_____ _____/_____/_____
Patient Name of Representative Date

_____ _____
Signature Patient or Representative Relationship to Patient

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____

_____

The Center for Advanced Surgery complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

Place Patient Label Here