ADVANCED SURGICAL CENTER
HIPPA ACKNOWLEDGEMENT
Signature Form

NAME_____
(Please PRINT)

Alternative. Communication Request:
On which of the following number (s) do we have permission to contact you?

__Home_____ May we leave a message for you at home? Yes____ No___
__Cell_____ May we leave a message or text message? Yes____ No___
__Work_____ May we leave a message for you at work? Yes____ No___
Protected Health Information Restrictions:
Other than you or your insurance company, whom may we talk to about your health care information?

_____ _____ _____
(Name) (Relationship) (Phone Number)
Do you have any health information that you would like to be kept confidential from any person or persons? Yes____ No_____
If yes, please indicate below the Type of Information and to whom the restriction applies:
_____
_____
_____

Privacy Notice Acknowledgement:
The patient identified above was provided with a copy of Advanced Surgical Center's Privacy Notice and Summary form.

- I Acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.
- I Acknowledge that I have been given the opportunity to request restrictions on use and/o disclosure of my protected health information. I also understand that my protected health information may still be used contrary to my request in the event of an emergency.
- I Acknowledge that I have received a copy of the Privacy Notice for Advanced Surgical Center.

_____ Date: _____
Patient or Personal Representative Signature

_____
Relationship to Patient