NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

X _____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____ Written Communication

☐ OK to speak to :_____

☐ OK to leave message with detailed information ☐ OK to mail to my home address

☐ Leave message with call back number only ☐ OK to mail my work/office address

☐ Work telephone: _____ ☐ OK to fax to _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only ☐ Other

X _____

Patient Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the disclosure of, and requests for, PHI to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to the authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information listed below, if completed properly, will constitute an adequate record.

Uses and disclosures for TPO (treatment, payment, operations) may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	**Disclosed to Whom (address or fax number)**	(1)	**Description of Disclosure Purpose of Disclosure**	**By Whom Disclosed**	(2)	(3)

Palo Alto Surgery Center

Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth
Gender: