Florida Surgical Clinic

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Patient Privacy Notice Acknowledgement Form

Patient consent to use and disclosure of health information for treatment, payment, or healthcare operations per HIPAA and FIPA regulations.

Florida Surgical Clinic LLC within its Privacy Policy has provided me the opportunity to review the information regarding the use and disclosure of my health information, and its compliance with HIPAA regulations. You should review our Privacy Policy for a more complete description of the potential release and use of such information, and you have the right to review such notice prior to signing this Consent Form. I understand I have the following rights and privileges: The right to review the provided HIPAA information prior to acknowledging this consent; the right to reject or revoke the use or disclosure of my health information; and the right to request restrictions as to how my health information may be used or disclosed for treatment or payment. We reserve the right to change the terms of our practice's privacy policy at any time. If we do make changes to the terms of our practice's privacy policy, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

TO BE COMPLETED BY THE PATIENT – PLEASE PRINT

PATIENT NAME: _____

RESTRICTIONS: _____

List the **full names and relationships** of those whom we **MAY** discuss your protected health information, including billing inquiries. (**Example**: Spouse, Children, Caregiver)

_____

List the **full names and relationships** of those whom we **MAY NOT** discuss your protected health information, including billing inquiries.

_____

COMMUNICATION:

May we leave a message at your home using doctor's/practice name: Y/N

May we leave a message at your work using doctor's practice name: Y/N

DO YOU HAVE ANY OF THE FOLLOWING ITEMS (check all that apply):

- ☐ Living Will
- ☐ Durable Power of Attorney
- ☐ Do Not Resuscitate
- ☐ Refuses Blood Transfusion
- ☐ None

READ AND SIGN:

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and accept the information of this consent.

Patient/Guardian Signature_____ **Date**_____

Print Name of person signing_____

If other than the patient signing, are you the legal guardian, custodian or have a Power of Attorney for this patient, for treatment, payment or healthcare operations?

Yes { } **No** { } **Relationship**:_____