NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The surgery center is committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. The terms of the privacy practices are to provide you with notice of its legal duties and privacy practices to protect your health information.

The center reserves the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new term of our notice effective for all health information that we maintain, including health information we created or received before we made the changes.

I understand that I have the right to request a restriction on how protected health information is used or disclosed to carry out treatment, payment and healthcare operations. This request for restriction must be in writing. If the center agrees to the restriction, the restriction is binding. However, the center is not required to agree to a requested restriction.

I acknowledge receipt of the center's Notice of Privacy Practices. I understand that by reading this consent form and signing, I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatments, payment activities and healthcare operations. I understand that I have the right to revoke this Consent at any time; the revocation must be in writing.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Below, please list the people that we are allowed to release / discuss your information to/with:

NAME: RELATIONSHIP TO PATIENT:

1._____

2._____

3._____

4._____