LAKE CITY SURGERY CENTER

NOTICE OF PRIVANCY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third=party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices.***

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRICTICE USE ONLY

I attempted to obtain the patients signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Signature:	Reason: