

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Do you authorize the staff of Northwest Surgical Specialists to discuss your medical condition with any other person? Please list full name(s), date of birth and relationship to patient below:

Name _____ DOB ___ / ___ / ___ Relationship _____

Name _____ DOB ___ / ___ / ___ Relationship _____

This area for staff notes (if any):

This form will be retained in your medical record.