SURGICAL CLINIC ASSOCIATES, P.A.

MRN#____________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and have a copy of 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 Terry Hickman, 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.

____
Print Patient's Name

______________________________ ____________________
Patient or Legally authorized individual signature Date Time

______________________________ ____________________
Printed Name if signed on behalf of the patient Relationship to Patient

PLEASE LIST AUTHORIZED PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

__________________________________ ____________________
Print Name of person/organization Relationship to Patient

__________________________________ ____________________
Print name of person/organization Relationship to Patient

__________________________________ ____________________
Print name of person/organization Relationship to Patient