PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. _____yes _____no
(initials) (initials)

I give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to anyone answering at my home telephone number or for the leaving of that information on my home answering machine. _____yes _____no
(initials) (initials)

I give my permission for affiliates of URGENT SURGERY ASSOCIATES to speak to

_____/_____
(name) (relationship)

regarding my healthcare, (including diagnosis, treatment, payment information and healthcare management and operations).

Signature: _____ Date: _____
Patient Signature (parent or guardian if patient is a minor)

Printed Name: _____