



NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth _____

Account Number _____

I am the: Patient Personal representative of the patient

We keep a record of the health care services that we provide to 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 authorized or compels us to do so. You may see your record or get more information about it by contacting our privacy officer.

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 of Puyallup Surgical Consultants.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship
(parent, legal
guardian, etc.)

Notation, if any, by staff:

This form will be retained in your medical record.
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