SURGICAL ASSOCIATES, P.C.
ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

Acknowledgment of Privacy Practice Notice

☐ I have received a copy of Surgical Associates, P.C. Notice of Privacy Practices.

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Surgical Associates, P.C. may disclose certain portions of my protected health information to all immediate family members and significant other. Immediate family members include spouse, mother, father, father/mother-in-law, son, daughter, son/daughter-in-law, step-son, step-daughter, step-mother, step-father, brother, sister, step-brother, step-sister, grandparents, grandchildren, step-grandparents and step-grandchildren. Significant other includes boyfriend, girlfriend and fiancé because such persons are involved with my health care or payment relating to my health care unless otherwise specified by me. **In that case, Surgical Associates, P.C. may disclose information that is directly relevant to the person's involvement in my health care or payment relating to my health.**

If you would like release of your information to be restricted, please ask for a separate form.

(Print) Patient's Name	Date of Birth	Signature of Patient/Parent/Guardian	Date

Witness by: _____
Signature of Clinic Personnel Date

I designate the following persons listed below as persons (**NOT** included in my immediate family or significant other as defined above) involved with my health care or payment relating to my health care for the purpose of Surgical Associates, P.C. making the limited disclosures described above. **I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.**

Print Name: _____

Print Name: _____

Print Name: _____

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Rights and Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.
☐ Patient/Parent/Legal Guardian stated they had already received the Notice of Privacy Rights and Practices.
☐ Other (explain) _____

_____
Signature of Clinic Personnel Date