ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I understand that as part of my health care, Acute Surgical Care, LLC originates and maintains records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care and treatment.

I have been given a Notice of Privacy Policies that describes in detail how information about me may be used within this medical practice and may be accessed by me or by others I authorize. I further understand that I have the following rights:

- To object to the use of my health information for directory purposes
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations
- To review the Notice of Privacy Policies before recieving health services

I also understand that as a part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsmile machine.

Once you have recieved and read this acknowledgement, please sign and date it, and return it to the receptionist at the front desk.

I acknowledge receipts of a Notice of Privacy Policies for Acute Surgical Care, LLC.

_____ _____

PATIENT SIGNATURE **DATE**

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PATIENT PRINT NAME