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Notice of Privacy Practice Acknowledgement

I acknowledge that Premiere Surgical has provided me with a copy of its Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act of 1996.

I authorize Premiere Surgical and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them should this information change: (Circle each answer.)

Home Telephone #	Yes	No
Answering Machine	Yes	No
Work Telephone #	Yes	No
Voice Mail	Yes	No
Cell Phone #	Yes	No
Fax to other Physicians involved in my care	Yes	No

Please list names, relationship and numbers of family members and/or friends you wish us to release medical information pertaining to your healthcare.

Name	Relationship	Phone Number



I do not wish any information pertaining to my healthcare to be released to family and/or friends.

Patient Signature: _____

Print Name: _____ Date: _____