SURGICAL GROUP OF SOUTH LAGUNA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS ORGANIZATION CREATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS. AS WELL AS DIAGNOSES, TREATMENT, AND ANY PLANS FOR FUTURE CARE OF TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE
- A MEANS OF COMMUNICATION AMONG THE HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND CLINICAL INFORMATION TO MY BILL
- A MEANS BY WHICH A THIRD-PARTY PAYOR (E.G. INSURANCE CARRIER) CAN VERIFY THAT SERVICES WERE ACTUALLY PROVIDED
- A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY AND OUTCOMES

I HAVE BEEN PROVIDED WITH A NOTICE OF PRIVACY PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES.

(NOTICE OF PRIVACY PRACTICES IS POSTED IN OUR OFFICE AND ON OUR WEBSITE)

*PATIENT OR GUARDIAN'S SIGNATURE:*____

*PLEASE PRINT PATIENT'S NAME:*____

*DATE:*____

*WITNESS:*____

*DATE:*____