NOTICE OF PRIVACY PRACTICES/PT. RIGHTS/OWNERSHIP

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS/OWNERSHIP NOTIFICATION

I acknowledge that I was provided a copy of the Notice of Privacy Practices, Patient rights and ownership notification.

I acknowledge that I have read, or have had the opportunity to read this notice and I understand this Notice.

_____

Patient's or Authorized Representative's Signature

_____

Authorized Representative (Please print if applicable) Relationship to Patient

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

☐ Home telephone: _____
- ☐ OK to speak to :_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Other _____

ADVANCE DIRECTIVES

South Coast Specialty Surgery Center will respect the Advanced Directive. However, the Center will NOT implement the DNR request. If you bring a copy of an advance directive or living will, a copy will be made and placed in your medical record. Should the need for a transfer to a hospital occurs, this copy would be forwarded to the hospital of transfer and they may honor these directives.

The law does not require that patients have or make an advanced directive.

☐ Yes, I have provided South Coast Specialty Surgery Center with a copy of my Advance Directive/ Living Will. The Center has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedures as scheduled.

☐ Yes, I have an Advanced Directive/Living Will, but I did not bring it to the Center. (There is no requirement that you bring it to the surgery center.

☐ I do not have an Advanced Directive/Living Will. I request the facility provide me with information about Advanced Directives. I understand that South Coast Specialty Surgery Center will not implement an Advanced Directives but will transfer this document with me should the need arise.

☐ I DO NOT have an Advanced Directive/Living Will. I DO NOT want information.

X _____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

Office Use Only

Information and Forms Provided to Patient: ☐ Yes ☐ No If NO please comment:

SOUTH COAST SPECIALTY SURGERY CENTER