Center of Surgical Specialists, P.C.
Advanced Knowledge. Expert Care.

Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Center of Surgical Specialists, P.C.'s Notice of Privacy Practices.

Signature of patient or patient representative Date

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For office use only

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

Signature of Employee Completing Form Date

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Authorization to Discuss Information

I, _____, authorize any physician or staff member of Center of Surgical Specialists, PC to discuss my medical condition and treatment by telephone, fax or in writing to the following individuals. No information will be given to any person not listed below.

I understand that this form may be updated and/or revoked at any time by me in writing.

Individual to give information to:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

Patient Name (Please print): _____

Date of Birth: _____