NEVADA SURGICAL SUITES

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been informed of, reviewed, and given the opportunity to secure a copy of the Nevada Surgical Suites Notice of Privacy Practices. The Notice of Privacy Practices explains how my protected health information may be used and disclosed for purposes of my treatment, payment for services, and the performance of our office health care operations. It also outlines my rights, as well as the responsibilities and duties of this office with respect to my protected health information. I understand that I may request a copy of the full Notice of Privacy Practices. Nevada Surgical Suites reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we obtain. I have read and agree with the terms, and I understand that I may request and receive a copy at any time.

Signature of Patient: _____

Date: _____

Signature of Legal Representative: _____

Relationship: _____

Signature of Witness: _____
(Witness attesting only that the above signature is that of the patient or the patients authorized representative.)

Date: _____