Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Southwest Florida Institute of Ambulatory Surgery, Inc. Notice of Privacy Practices.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

By signing below, I give permission to acquire my electronic medication records from the pharmacy.

May we mail your home or other designated location any items that assist the practice in carrying treatment/healthcare operations, such as appointment reminders, insurance items, and lab results?

☐ Yes ☐ No

May we leave a message on your telephone answering machine?

☐ Yes ☐ No

May we leave a message with a member of your household regarding appointments, lab results, and insurance?

☐ Yes ☐ No

If yes, whom: ______________________ Relationship: ______________________

If yes, whom: ______________________ Relationship: ______________________

May we contact your work place?

☐ Yes ☐ No

I understand the contents of this Notice.

____ ____________________

Patient or Parent or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient) Date