Privacy Practices

Joint Notice of Privacy Practices for Health Information (NPP)

Effective April 14, 2003, the law requires that Surgery Center at Hamilton provide patients with a copy of its Notice of Privacy Practices for Health Information. This will be provided at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you the patient or the patient's personal representative, authorized agent or individual Involved in the patient's medical care, acknowledge receipt of such information.

Facility Directory: Family and Friends Access Form

It is the policy of Surgery Center al Hamilton to comply with the requirements of the national, state and organizational framework for health information privacy protection. This includes the process for creating and maintaining a facility patient directory for the purpose of providing information to family, friends, the public and other third party entities. This policy protects the rights of our patients to restrict or prohibit some or all of the uses below. The facility directory may include:

1. · The patient's name
2. The patient's location in the facility
3. The patient's condition describe in general terms that does not communicate specific medical information (i.e. the condition can be described as "fair", "critical", "stable")
4. The individual's religious affiliation

In order to communicate your health status or permit any uses or disclosures of protected health information (PHI) b *patient identified family and friends, we* will need your oral or written permission.

I reserve the right b my privacy as described:

O I wish to have the above information included in the patient facility directory.

O I agree to have the Surgery Center at Hamilton communicate any uses and disclosures to my family and friends, providing they are involved with my care or payment for this visit.
Exception;_____

O No, Ido not wish to have the above information included In the patient facility directory.

0 I do not agree to have Surgery Center at Hamilton communicate any uses and disclosures of PHI to my family and friends upon request.

Patient Signature: _____ Date: _____

If not patient, Print Name: _____ Relationship to Patient: _____

Guardian Signature: _____ Date: _____

Witness Signature: Date:

For Official Use:
I have provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgement of receipt for the following reasons:

I have attempted to provide the patient (or personal representative) a copy of NPP, but was unable to do so for the following reasons:

Signature of Facility Representative: _____ Date: _____

Print Name: _____

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