CENTER FOR
Minimally Invasive Surgery, PLLC
The Advanced Laparoscopy Experts

HIPAA - Notice of Privacy Practices Acknowledgment

CFMIS has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your healthcare information may be used and disclosed, how you can access your healthcare information and whom to contact if you have questions, concerns or complaints.

We may change the Notice of Privacy Practices at any time and you may contact the Office Manager at 253-572-7120 to obtain a current copy of the NPP or ask questions.

By my signature below, I agree that I am aware that I can ask for a copy of the NPP of CENTER FOR MINIMALLY INVASIVE SURGERY at any time.

_____

Printed Name of Patient

_____ Date: _____

Signature of Patient or Legal Guardian

_____ _____

Printed Name if not signed by the Patient Relationship

[ ] CHECK THIS BOX IF YOU GIVE YOUR ***PERMISSION*** TO RELEASE YOUR HEALTHCARE INFORMATION TO FAMILY MEMBERS OR OTHER PRIVATE PARTIES.

[ ] I give my permission to leave a voice mail message on my recorder regarding my healthcare.

[ ] CHECK THIS BOX IF YOU ***REFUSE*** PERMISSION **AND WE WILL NOT RELEASE YOUR HEALTHCARE INFORMATION TO FAMILY MEMBERS OR OTHER PRIVATE PARTIES. (Please be advised this means we will only speak to you on the phone and only you may pick up any prescriptions).

**WE WILL SHARE YOUR RECORDS AND INFORMATION WITH ALL INSURANCE COMPANIES ,HEALTHCARE PROVIDERS AND FACILITIES RELATED TO YOUR CARE IF REQUESTED.

*This form will be retained in your medical record.

_____

For Office Use Only

Office staff completer below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date:_____ Staff member initials: _____
Reasons:_____
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[ ] I have reviewed the above permission information. Date: _____ initial_____
[ ] I have reviewed the above permission information. Date: _____ initial_____
[ ] I have reviewed the above permission information. Date: _____ initial_____

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