Surgical Care AFFILIATES
SANTA CRUZ ENDOSCOPY CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

****You may refuse to sign this acknowledgement****

Surgical Care Affiliates will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.

The terms of the notice may change with time and we will always post the current notice at our center, on our website, and have copies available for distribution.

I, ____________________________________, have received a copy of this center's Notice of Privacy Practices.

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Please Print Name

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Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

€ Individual refused to sign
€ Communications barriers prohibited obtaining the acknowledgement
€ An emergency situation prevented us from obtaining acknowledgement
€ Other (Please Specify)________________________________
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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed consent in the patient's Medical Record