Indio Surgery Center

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of Indio Surgery Center. Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

This notice is effective as of April 1, 2013 and we are required to abide by the terms of the **Notice of Privacy Practice** currently in effect.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us either by phone or mail at: **INDIO SURGERY CENTER**

46-900 Monroe St. #B-201

Indio, CA 92201

I acknowledge receipt of the Notice Of Privacy Practices if Indio Surgery Center.

Signature: _____ Date: _____

(Patient/Parent/Conservator/Guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgement was not obtained.

Signature of
provider representative:_____ Date:_____

For more information about HIPPA or to file a complaint contact the following:

The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Ave., S..W., Washington D.C.20201

(202) 619-0257 or toll free (877) 696-6775