NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the University Center for Ambulatory Surgery, LLC Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully.

I understand that the University Center for Ambulatory Surgery, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact the University Center for Ambulatory Surgery, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: (Print) _____

Signature of Patient/Legal Representative: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I have made a good faith effort and attempted to obtain the patient's signature on this form of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials:

Please document the reason you were unable to obtain the signature:

_____

_____

_____