Innovative Surgical Care, Assoc.

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HIPAA Notice of Privacy

Date:

Patient Name _____ DOB _____

I, _____, have received, read and understand the privacy practice notice provided by Innovative Surgical Care.

Signature: _____

Innovative Surgical Care takes every precaution to follow all HIPAA privacy guidelines to protect our patients' privacy. There will be times when we need to contact you when you are not in the office.

During these times, which way(s) do you authorize our staff to contact you:
(check all that apply)

_____ Authorize Voicemail Messages for appointment reminders and callback requests.

_____ Authorize a message to be left with someone other than you (please designate whom you authorize)

Authorized Person: _____ Relationship:_____

Authorized Person: _____ Relationship:_____

Emergency Contact _____ Phone Number _____

_____ Authorize mail correspondence