Privacy Practices Acknowledgement

By signing this form, you acknowledge that you have been informed that Falconhead Surgery Center (FSC) provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Falconhead Surgery Center may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

☐ Contact me by phone at home _____

☐ Work _____ ☐Cell _____

☐ FSC may leave a message on my voice mail/answering machine

☐ FSC may speak to anyone who answers the phone

☐ FSC may only speak to _____

☐ FSC may leave a message for me at my work phone number

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (512) 900-1006.

Signature_____ Date_____
(Patient/Parent/Conservator/Guardian

Inability to obtain acknowledgement: *To be completed only if no signature is obtained:*

☐ Patient lacks the ability to understand the Notice of Privacy Practices

☐ Other_____

Signature_____Date_____
(Provider Representative

Patient Label/Printed Name_____