SURGICAL INSTITUTE OF SOUTH DAKOTA, PC

Acknowledgement of Receipt of Privacy Notice:
I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Authorization to Disclose Protected Health Information to Family/Friends:

☐ I do not want my information to be shared with family/friends.

☐ I hereby authorize Surgical Institute of SD to discuss my medical history, plan for treatment, test results, and other protected health information with the following individuals: *(PLEASE PRINT)*

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Cell Phone Acknowledgement:
By providing my wireless/cell phone number, I consent to receive telephone calls (including autodialed and/or prerecorded calls) or text messages from the Surgical Institute and/or any of its agents.

Note: This form must be signed by the patient unless the patient is a minor child or we have a Medical Power of Attorney on file giving another individual authorization to sign on the patient's behalf.

Signature: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____
PLEASE PRINT

*If this form is not being signed by the patient, please indicate name and relationship to the patient:

Name: _____ **Relationship:** _____
PLEASE PRINT

Office Use Only:

Signed form received by: _____

☐ Acknowledgement refused. Please list reason for refusal & efforts to obtain: _____

_____

_____

Surgical Institute of South Dakota

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David A. Strand, MD, FACS
Bradley C. Thaemert, MD, FACS
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Summary of Notice of Privacy Practices

Surgical Institute of South Dakota, P.C.

Privacy Officer: Mark A. Hatting, Executive Director

The following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices (the "Notice"). This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services, and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services, and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition, or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. **Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
   - **a)** You may request restrictions on certain uses and disclosures of your information
   - **b)** You may request that you receive your information from us in a certain way
   - **c)** You may inspect and copy your medical records
   - **d)** You may request an amendment to any record you believe is inaccurate
   - **e)** You may request an accounting of disclosures made of your records

4. **Changes to the Notice.** We reserve the right to change the Notice. If we do so, we will post it in our office and on our website and provide a copy upon request.

5. **Complaints.** You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.