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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Summary of Notice of Privacy Practices

Surgical Institute of South Dakota, P.C.

Privacy Officer: Mark A. Hatting, Executive Director

Your Information. Your Rights. Our Responsibilities.

This notice describes a brief summary of how medical information about you may be used and disclosed and how you can get access to this information. **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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions