Notice of Privacy Practices (NPP) Acknowledgement

A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access, amend medical information, request an accounting of disclosures, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

By signing below, I hereby acknowledge I have received a copy of this office's Notice of Privacy Practices:

Name of Patient:

_____ _____ _____
(Please Print Name) (Please Sign) (Date of Signature)

Name of Personal Representative to Patient (if applicable):

_____ _____
(Please Print Name of Representative) (Relationship to Patient)

_____ _____
(Please Sign) (Date of Signature)

Authorization to Release Information:

I, _____ (Patient Name) hereby authorize Okatie Surgical Partners (Dr. Cotter and staff) to give the following people information concerning my health, treatment, billing and/or insurance information:

☐ Spouse Name: _____ ☐ Significant Other Name: _____

☐ Parent Name: _____ Name: _____
(Mother) (Father)

☐ Any Specified Person Name: _____
(Name and relationship)

Or

☐ Only give the following information to myself

The following information may be given to the above individuals:

____ Appointment time ____ Test/Lab, X-ray results ____ Medications ____ Procedures
____ Any other information regarding my health ____ Billing and/or Insurance Information
____ **Message may be left on my answering machine and/or voice mail**

I understand that I may terminate this consent at any time by giving written notice to Okatie Surgical. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signed: _____ Date: _____ Witness: _____ Date: _____
(Patient/Parent/Legal Guardian)

For Internal Use Only:

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The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____ _____
Signature of employee validating identity Date

If applicable, reason patient's written acknowledgement could not be obtained:
_____ Individual refused to sign acknowledgement
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please specify)