

Lincoln Surgical Associates, APMC

Acknowledgement of Review of Notice of Privacy Practices

I authorize the use and disclosure of individually identifiable health information relating to me, which is called “protected health information” under a federal health privacy law. I acknowledge receipt of this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Authority or Relationship to Patient

Date

I _____ decline receipt of Lincoln
Patient

Surgical Associates’ copy of Notice of Privacy Practices. I understand my rights and entitlements, but so choose not to receive a copy.

I _____ certify that I have made a good
Provider

faith effort to obtain written acknowledgment of receipt of this Notice of Health Information Privacy Practices, but the acknowledgment was not obtained because:

By: _____

Date: _____

Witness: _____

Date: _____