NYSP NEW YORK SURGICAL PARTNERS
Hernia Institute | Cancer Center | Gastrointestinal Center
Affiliated with St. Francis Hospital, Roslyn, NY • Catholic Health Services of Long Island

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____ _____
Signature of Patient or Personal Representative — Print Name of Patient or Personal Representative

_____ _____
Description of Personal Representative's Authority — Date

_____ _____
Signature of Facility Representative — Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. New York Surgical Partners may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit New York Surgical Partners to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

_____ _____
(Relationship to patient)

_____ _____
(Relationship to patient)

I expressly permit New York Surgical Partners to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel.# _____

Office voicemail: Tel.# _____

Other (specify): _____ Tel.# _____

_____ _____
Signature of Patient / Personal Representative Parent/Guardian — Date