University Surgical Associates
Acknowledgement of Receipt of Notice of Privacy Practices

To our patients…

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights in this information. We ask you to review our Notice of Privacy Practices that describes your rights and our legal duties with respect to your health care information.

How we use health care information:

In summary, we use information to:

- provide treatment to you
- ensure appropriate payment for the treatment we provide, and
- monitor the quality of our operations

When we may disclose information:

Under certain limited cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to health or safety, for workers' compensation, to reduce public health risks, for health oversight, and in certain case for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

Your information rights:

We create a record of the care we give you. You have the following rights to this information:

- You have the right to know how we use your health information, who we can give it to, and your rights in this information.
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in our record unless your doctor has indicated this would be harmful to you or someone else.
- You have the right to ask us for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have any questions, please speak to our information privacy official, David T. Harrington, M.D., (401) 444-2892.

Signature: _____ Date: _____

Print Name:_____

UNIVERSITY SURGICAL ASSOCIATES
Permission to Disclose Medical Information

I hereby authorize University Surgical Associates office to speak to the following people regarding my medical condition.

NAME	RELATIONSHIP

I understand I may revoke this authorization at any time by informing the physician's office in writing.

Patient Name (print)	Date of Birth
Patient Signature	Date
Guardian Signature/Relationship	Telephone