

**NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES-  
ACKNOWLEDGEMENT**

WE KEEP A RECORD OF THE HEALTH CARE SERVICES WE PROVIDE YOU. YOU MAY ASK TO SEE AND COPY THAT RECORD. YOU MAY ALSO ASK TO CORRECT THAT RECORD. WE WILL NOT DISCLOSE YOUR RECORD TO OTHERS UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHORIZES OR COMPELS US TO DO SO. YOU MAY SEE YOUR RECORD OR GET MORE INFORMATION ABOUT IT BY CONTACTING , SPORTS MEDICINE CENTER/SPORTS MEDICINE CENTER DAY SURGERY MANAGER. OUR **NOTICE OF PRIVACY PRACTICE** DESCRIBES IN MORE DETAIL HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS YOUR INFORMATION.

**BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

---

PATIENT/GUARDIAN SIGNATURE	DATE	TIME
----------------------------	------	------

---

PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT RELATIONSHIP ( PARENT, GUARDIAN )

---

WITNESS (STAFF MEMBER)	DATE	TIME
------------------------	------	------

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD.

**BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF PATIENTS RIGHTS AND RESPONSIBILITIES.**

---

PATIENT/GUARDIAN SIGNATURE	DATE	TIME
----------------------------	------	------

LAST UPDATE: 6/03/2009  
REVISED UPDATE: 6/4/2009  
REVIEWED: 6/4/2009  
REVIEWED, UPDATED 01/2011