

El Camino Ambulatory Surgery Center LLC
2480 Grant Road
Mountain View, CA 94040
650.961.1200



**EL CAMINO AMBULATORY SURGERY CENTER
NOTICE OF PRIVACY PRACTICES / HIPAA ACKNOWLEDGEMENT**

Name: _____
(Please print)

It is important that you provide us with your direct contact information and the names of persons that we may share your protected health information while you are in our care.

Alternative Communications Request: At which of the following number(s) do we have permission to contact you?

- Home: _____ May we leave a message for you at home? Yes No
- Cell Phone: _____ Work: _____

Protected Health Information Restriction:

Other than you, your surgeon and other health care providers or your insurance company, whom may we talk to about your health care information?

(Name) (Relationship) (Phone Number)

Do you have any health information that you would like to be kept confidential from any person or persons?
 Yes No

If yes, please indicate below the type of information and to whom the restriction applies:

Privacy Notice Acknowledgement:

- I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.
- I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected health information. I also understand that my protected health information may still be used contrary to my request in the event of an emergency.
- I acknowledge that I have reviewed the Center's Privacy Practices made available to me at www.elcaminosurgery.com or hard copy upon admission.

YOUR SIGNATURE BELOW IS REQUIRED UPON ADMISSION TO THE CENTER

Patient or Personal Representative Signature

Date

Relationship to Patient