



Patient Name
DOB

PATIENT PRIVACY

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information.

BY SIGNING BELOW I ACKNOWLEDGE BEING NOTIFIED OF THE PRIVACY PRACTICES OF BELLONA SURGERY CENTER.

Check here if you wish to receive a copy of the Bellona Surgical Center's Notice of Privacy Practices.

Patient Name _____

Signature: _____

Date: _____

If patient is unable to consent on his/her own behalf, then a parent/guardian must sign below:

Signature of Parent/Guardian _____

Relationship to Patient: _____

Date: _____

Signature of Witness _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
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