Acknowledgement of Notice of Privacy Practices and HIPAA Consent

I hereby acknowledge that I received Apex Surgical Partners Notice of Privacy Practices and HIPAA Notice:

Patient Name: _____ (print) Date of Birth: _____

Patient (or representative) Signature: _____ Date: _____

Additional Persons Included in Your Care

Contact persons with whom we may discuss your care and give test results. Please note, if you want a spouse, significant other, and/or children to be included, you must list them below.

Name: _____Relationship: _____Phone #: _____

Name: _____ Relationship: _____Phone #: _____

Messages

May we leave confidential information on voice mails or answering machines listed below? ** Please note, if voice mail or answering machine message is not identified with a name, we may not leave a message. **

PREFERRED

Home Phone: _____ _____YES NO _____

Work Phone: _____ _____YES NO _____

Cell Phone: _____ _____YES NO _____

Email: _____ _____ YES NO _____

(If you checked "yes", you must provide us with an e-mail address. We will not send test results or health information via email. This communication should happen through the patient portal for information security.)

Agreement

I'm aware that this consent will remain in effect until such time that I provide written notification to end this agreement. I'm aware that no other person than those listed above will be allowed to discuss my care, be given financial information, or be allowed to make or cancel appointments on my behalf.

Participation in Health Information Networks: We participate in the Colorado Regional Health Information Organization (CORHIO) which is a secure computer network which provides safe and efficient ways to share medical information with other health care providers. For example, if you require emergency medical care while you are traveling, providers at other health care facilities in Colorado could have access to your medical information to assist them in caring for you. By participating in this network and other electronic information exchanges, we intend to provide timely information to health care providers involved in your care. If you do not want your information to be shared through CORHIO, you may "opt out" by contacting the person listed in Section V below. This is an "all-or-nothing" choice, because CORHIO cannot block access to some types of medical information while at the same time permit access to other medical information. Opting-out of CORHIO may limit your health care providers' ability to provide the most effective care for you.

Signature of Patient/Authorized Person: _____ Date_____