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**WASILLA**

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**ANCHORAGE**

2751 DeBarr Road, Bldg. B, Ste. 310 **⏐** Anchorage, AK 99508

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**HIPAA Acknowledgement and Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have been provided the HIPAA Notice of Privacy Practices by ***Surgical Specialists of Alaska***. I acknowledge that the HIPAA Notice of Privacy Practices describes the use and disclosure of my protected health information (PHI), and identifies my rights and the duties of which ***Surgical Specialists of Alaska*** must uphold.

**Please initial the following:**

\_\_\_\_\_ Use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare

operations (TPO).

\_\_\_\_\_ Call my home or other designated locations to speak in person or leave a voice message about any items that assist

the practice in carrying out TPO. Including, but not limited to: appointment reminders, insurance items, my clinical

care, and laboratory and diagnostic results.

\_\_\_\_\_ Send mail to my home or other designated location any items that assist the practice in carrying out TPO.

Including, but not limited to: appointment reminders, patient statements, and insurance items.

\_\_\_\_\_ I have the right to request that ***Surgical Specialists of Alaska*** restrict how my PHI is used and/or disclosed to

carry out TPO. However, the practice is not required to agree with my requested restriction, but if they do, they are

bound to this agreement.

\_\_\_\_\_ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance

upon my prior consent. If I do not sign this consent, ***Surgical Specialists of Alaska*** may decline to provide

treatment to me.

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to be released to the following:

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family or Friends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] *Information is not to be released to anyone*

I authorize ***Surgical Specialists of Alaska*** to leave voice messages if I am not available to take a phone call:

[ ] Home [ ] Cell [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] You may leave a detailed message

[ ] You may leave a message asking me to return your call

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

Please note that this will expire one year from date of signature.