

**Central Carolina Surgery, P. A.**  
**1002 North Church Street, Suite 302**  
**Greensboro, NC 27401**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand **Central Carolina Surgery, P. A.'s Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that **Central Carolina Surgery, P. A.** has the right to change its **Notice of Privacy Practices** from time to time and that I may contact **Central Carolina Surgery** at any time at the address above to obtain a current copy of the **Notice of Private Practices**.

*I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.*

Patient name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For office use only**

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

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_