Waverley Surgery Center
400 Forest Avenue
Palo Alto, CA 94301
650.324.0600

WAVERLEY 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.waverleysurgery.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