Campus Surgery Center
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650.991.2000

Campus Surgery Center

CAMPUS SURGERY CENTER
NOTICE OF PRIVACY PRACTICES / HIPAA ACKNOWLEDGEMENT

Name: _____
(Please print)

It is important that you provide us with your direct contact information.

Alternative Communication 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 _____ May we leave a message on your cell phone? ○
Yes ○ No

○ Work _____

Privacy Notice Acknowledgement

- I acknowledge that I have reviewed the Center's Privacy Practices made available to me at www.campussurgery.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

Patient Label