Surgical Specialists of Trinity, PA

PRIVACY NOTICE

I have reviewed/received a copy of the Surgical Specialists of Trinity, PA HIPPA (Health Information Portability and Privacy Act) notice.

Signature:____ Date:______________________

DESIGNATED PERSON(S)

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, medical procedures, and/or surgery) with: ( ) Spouse ( ) Children ( ) Parents
( ) Other(s)_________________________________

Please list the family members or significant others, if any, whom we may inform about your medical condition, and in case of an emergency.

Name:___________________________ Relationship:____________________ Phone:_______________

Name:___________________________ Relationship:____________________ Phone:_______________

Name:___________________________ Relationship:____________________ Phone:_______________

Messages may be left on my answering machine/voicemail regarding my health status, test results, and appointments: ( ) Yes ( ) No

Do you wish correspondence to be confidential? ( ) Yes ( ) No

Signature:____ Date:______________________