Wisconsin Surgery Center, LLC
Ambulatory Surgical Center

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of personal health information. (PHI) The individual is also provided the right to request confidential communications or that if communications of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/ office address
- ☐ O.K. to fax to this number
- ☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Other _____

I hereby give Wisconsin Surgery Center staff permission to discuss my medical care, lab results, billing, and medication, with the following individuals:

- ☐ Spouse _____
- ☐ Son/Daughter _____
- ☐ Other _____

ACKNOWLEDGEMENT:

I acknowledge that i have received a copy or reviewed the Privacy Practices for Wisconsin Surgery Center.

If at any time you would like this permission revoked, you will need to contact Wisconsin Surgery Center

Patient Signature/ Representative _____ Date _____

Print Name/Relationship _____ Birth Date _____