HIPAA Privacy Information

YOUR NAME: _____ DOB: _____

It is customary for JLSurgical, LLC, to communicate with you regarding appointment, medical, and payment information via telephone, cell, mail, or our secure Patient Portal. By default, we utilize the telephone numbers and address that you provide us on our "Patient Information" form and/or those that were communicated verbally when making your appointment. We may also use what was provided to the health care facility where you received the services of JLSurgical, LLC. In addition, we may transfer your PHI to other treating health care providers and to your insurance carrier electronically or by fax. You have the right to request we communicate with you by alternative means. Please make your request in writing to JLSurgical, LLC, 325 East Main Street, Ramsey, NJ 07446 ATTN: Privacy Officer

Who may we contact in case of an emergency?

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Tele #: _____ DOB: _____

********** MAY WE DISCUSS YOUR MEDICAL INFORMATION **********
(MEDICAL HISTORY, TEST OR LAB RESULTS)
WITH THE EMERGENCY CONTACT YOU NAMED ABOVE?
YES _____ NO _____

Is there someone else OTHER THAN those permitted under the guidelines of HIPPA for treatment, payment, and health care operations **who we may discuss your medical information?**

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Tele #: _____ DOB: _____

I acknowledge and understand the notice of privacy practices from this office detailing the uses of my medical information, communication practices, and my rights concerning my information kept on record at this office. I understand that a detailed notice is available for my immediate review or a copy for my records.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by Patient Representative, give relationship: _____

Signature of Witness: (Office) _____