



DANIEL C. MACMILLAN, M.D.  
SANDRA N. SENESHEN, M.D.  
WENDELL L. BAILEY, M.D.  
G. BRICE HAMILTON, M.D.

### WRITTEN ACKNOWLEDGEMENT OF PRIVACY POLICY

I have been provided with a copy of Surgical Associates Southern Indiana's Privacy Policy. Surgical Associates Southern Indiana offers this information and requests your acknowledgement in an effort to comply with the new national regulations established to protect the privacy of your medical information (Health Information Portability Accountability Act- HIPAA).

If you choose not to sign this acknowledgement, we are obligated to document your choice in your medical record to comply with the HIPAA guidelines.

Your willingness or refusal to sign this acknowledgement will not influence your medical treatment in any way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### PATIENT RECORD OF DISCLOSURE

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

For Appointments, Outpatient Testing, Surgeries or any questions our office might have when scheduling any of the above, I wish to be contacted in the following manner:

**(CHECK ALL THAT APPLY):**

**HOME TELEPHONE:** \_\_\_\_\_  
 OK to leave message with detailed information.  
 Leave message with call-back number only.

**WORK TELEPHONE:** \_\_\_\_\_  
 OK to leave message with detailed information.  
 Leave message with call-back number only.

**WRITTEN COMMUNICATION:**  
 OK to mail to mail to my home address.  
 OK to mail to my work/office address.  
 OK to fax to this number: \_\_\_\_\_

Please list family members that we may discuss your Appointments, Test Results, Surgeries, and Medical Records.

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (Printed)