Notice of Privacy Practices

By signing this form, you acknowledge that you have been informed that Spokane Valley Ambulatory Surgery Center (SVASC) provides information about how we may use and disclose your protected health information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

Spokane Valley Ambulatory Surgery Center may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

Please check all that apply:

[ ] Contact me by phone at home _____

[ ] Work _____ [ ] Cell_____

[ ] SVASC may leave a message on my voice mail/answering machine

[ ] SVASC may speak to anyone who answers the phone

[ ] SVASC may only speak to _____

[ ] SVASC may leave a message for me at my work number

Questions and/or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer, at 509-340-8340.

Signature _____ Date _____
(Patient/Parent/Guardian) (Mo/Day/Yr)

Inability to obtain acknowledgement: (To be completed only if no signature is obtained)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communication barriers prohibited obtaining the acknowledgement.
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (Please Specify) _____
_____

Signature _____ Date _____
(Provider Representative) (Mo/Day/Yr)