SQUARE MEDICAL CENTER

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge that I have received or been provided access to ***Square Medical Center's Notice of Privacy Practices (NPP)***. The Notice explains how my protected health information may be used and disclosed and describes my privacy rights.

Square Medical Center may use or disclose my health information as permitted by law for:

- **Treatment:** providing and coordinating my medical care with health care professionals involved in my care.
- **Payment:** billing health plans or other responsible parties for services provided.
- **Health Care Operations:** activities necessary to operate the practice, coordinate services, and improve quality of care.

I understand that I may request restrictions on certain uses or disclosures of my health information. Square Medical Center is not required to agree to every requested restriction except when required by law.

My signature confirms receipt or access to the Notice of Privacy Practices and does not waive any of my privacy rights.

OPTIONAL AUTHORIZATION TO DISCUSS INFORMATION WITH ANOTHER PERSON

I authorize Square Medical Center to discuss my health information with the person identified below, subject to applicable federal and state privacy laws. I understand that this authorization is optional and may be revoked in writing as permitted by law.

Name: _____

Relationship: _____

Phone Number: _____

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received or been provided access to Square Medical Center's Notice of Privacy Practices.

_____	_____	_____
Patient Full Name	Signature	Date

Square Medical Center
Phone: (305) 395-5078 | Email: office@squaremedicalcenter.com