Fall General Surgery, LLC
Summary Notice

I acknowledge that I have received from Fall General Surgery, LLC a written notice of Fall General Surgery, LLC's privacy practices for protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the notice also contains:

- A description of the types of uses and disclosures that Fall General Surgery, LLC is permitted to make for treatment, payment or health care operations with or without my written authorization
- A description of each of the other purposes for which Fall General Surgery, LLC is permitted or required to use or disclose protected health information without my written authorization
- A description of uses or disclosures that may be limited or prohibited by law
- The description contains sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rule and other applicable law
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right
- A statement describing the Fall General Surgery, LLC duties under the federal privacy law
- A statement describing how I may express concern to the Fall General Surgery, LLC and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated
- I have received information explaining how to contact Fall General Surgery, LLC for further information and the effective date which the notice is first in effect

Signed____ Date_________________

Minor Patient Name_________________________________

Please note that for us to release copies of your medical records to family members you must sign a release form; *this includes spouses.* Just ask the receptionist for the form.

Please list below any people you would like to have access to your medical information *on a regular basis*, for example: your care-giver, spouse, brothers, sisters, moms, dads, sons, daughters, etc.

____

Patient
Signature ____ Date ________________________________

By signing above, I allow Fall General Surgery and its staff members to relate information regarding my care to the above named person(s). I understand that this is effective for one (1) year from the date of my signature and does not grant access to my medical record.