Fall General Surgery, LLC
HIPAA Summary Notice

By signing below, I acknowledge that I have received information from Fall General Surgery, LLC on how to obtain a written notice of Fall General Surgery, LLC's privacy practices for protected health information. I understand the written notice will contain a description of how medical information about me may be used and disclosed and how I may access this information. I have received information explaining how to contact Fall General Surgery, LLC for further information and the date this notice was first effective. I understand that the written 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

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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.

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On the line below:

***Please LIST the Name*(s) of any person; for example: your care-giver, spouse, brothers, sisters, moms, dads, sons, daughters, etc., you would like to have *Access* to your *MEDICAL/BILLING INFORMATION*; for example: verifying appointments, picking up prescriptions, speaking to our billing department about your bill, speaking with the doctor about your care, etc., *on a regular basis*. *If you Prefer Not to list anyone below, please state No One or None*.**

List or No One _____

By signing below, I give permission for the above named people to have access to my medical and/or billing information on a regular basis and it allows Fall General Surgery LLC and its staff members to relate information regarding my care to these named people. 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.

Sign Here _____ _____

Signature of patient (or parent/guardian if patient is a minor) **Date**

Patient Name if the Patient is a Minor or a Patient Representative signed: _____