

SURGICAL ASSOCIATES OF PALM BEACH COUNTY

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Boca Raton, FL 33431-6464
561-395-2626

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM**

I, _____ have read a copy of Surgical Associates of
Patient Name

Palm Beach County's **Notice of Privacy Practices**.

AUTHORIZATION FOR PATIENT CONTACT

I, the undersigned, do hereby authorize Surgical Associates of Palm Beach County to contact me by:

Telephone: _____ Yes _____ No _____

Fax: _____ Yes _____ No _____

E-mail: _____ Yes _____ No _____

I, the undersigned, do hereby authorize Surgical Associates of Palm Beach County to contact and/or discuss my healthcare with the following **alternative source** (example: family member, etc.).

Alternative Source Name: (Please Print)

Relationship to the Patient **Telephone Number**

Patient Signature: _____

Print Name: _____

Date: _____