ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received San Diego Surgical Specialists' Notice of Privacy Practices ("Notice").

_____ _____
Signature (Patient or Authorized Representative) Date

_____
Printed (Patient or Authorized Representative)

Preferred contact number:_____ OK leave a detailed message? Y N

We value your privacy, and will not discuss any aspect of your medical condition with any friends or family members unless you designate them below. We will still require your signature before releasing copies of your medical records.

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

I authorize San Diego Surgical Specialists to discuss my medical history, including such things as diagnosis and date and time of surgery, with the above listed people.

_____ _____
Signature Date