

NORTHWEST HILLS SURGICAL HOSPITAL
6818 AUSTIN CENTER BLVD, SUITE 100
AUSTIN, TX 78731

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES***

You may refuse to sign this acknowledgement

Northwest Hills Surgical Hospital will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.

I, _____, have received a copy of this facility's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Hospital Use Only For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's Medical Record