COASTAL SURGERY SPECIALISTS

1411 Physicians Dr, Wilmington, NC 28401

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Coastal Surgery Specialists.

_____ _____

Patients/Guardian Signature Date

FAMILY/FRIEND PHI AUTHORIZATION FORM

In accordance with Coastal Surgery Specialists' *Notice of Privacy Practices* Section B, Item 5, we may share your personal health information with a family member, relative, friend or other person identified by you. Please list below the names of ALL persons you would permit to have such access to your personal health information.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

Please note: In calling our physicians or our office for medication information/advice, we would prefer to speak with the patient directly. **Any person calling should be able to identify the patient's date of birth, physician name, and problem/procedure performed.** This enables us to further protect your right of privacy

This authorization will continue until revoked or terminated by the patient upon submission and receipt of a written revocation to Coastal Surgery Specialists.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

_____ _____

Signature of Patient Representative Relationship of Patient Representative