2821 Proctor Road
Sarasota, Fl 34231
941-870-1872

Authorization for Release of Medical Records

I Authorize Sarasota Ambulatory Surgery Center to release my health information records to "my performing physician" _____ to enable a comprehensive review of my medical care.

This authorization shall be effective immediately. I understand I have the right to revoke this authorization in writing, at any time by sending written notification to:

Sarasota Ambulatory Surgery Center
Attn: Medical Records
2821 Proctor Road
Sarasota, Fl 34231

_____ _____
Patient's Signature / Power of Attorney Date

_____
Personal Representative

SARASOTA AMBULATORY SURGERY CENTER – Pre-Anesthesia Assessment

The amount of medication given to you during your procedure is adjusted according to your height and weight.

Current: Height?_____ Weight?_____ Age?_____

Have you had surgery before? Yes ☐ No ☐ If so, when and what kind of surgery?

_____

_____

Have you or any members of your family had problems, INCLUDING FEVER, with prior anesthetics? (blood rel)
Yes ☐ No ☐ If yes, explain: _____

Have you had any drug reactions or drug allergies? Yes ☐ No ☐ SEE MEDICATION/ALLERGY LIST

_____

Circle if you have any of the following allergies: Latex Iodine / Betadine / Seafood / Shellfish Morphine / Demerol Sulfur/Eggs IVP dye

Do you have or have you had any of the following?	Yes	No	If yes, give additional information
A. Thyroid or goiter problems			
B. Diabetes or hypoglycemia			
C. Epilepsy or seizures			
D. High blood pressure or stroke			
E. Heart disease or mirtal valve prolapse			
F. Chest pain or angina (pacemaker/defib)			
G. Lung disease or mitral valve prolapse			
H. Chronic cough, asthma, or shorthness of breath			
I. Hepatitis, cirrhosis, or jaundice			
J. Kidney disease			
K. Ulcers or hiatal hernia			
L. Anemia or sickle cell disease			
M. Recent weight loss			

Are you now or have you ever been in a drug recovery program? Yes ☐ No ☐
Do you drink more than 2 alcoholic beverages daily? Yes ☐ No ☐ If so, how many?
Do you smoke? Yes ☐ No ☐ If yes, _____Packs per day for_____ years.
Do you vape? Yes ☐ No ☐ If yes, _____Times per day for_____ years.

PLACE PATIENT ID LABEL HERE

Have you had broken facial bones?			
Have you had back, jaw, or nose surgery?			
Do you use eye drops or wear contacts lens?			
Do you have loose teeth, caps crowns, or dentures?			
Have you had an abdominal chest film or EKG?			
Do you have back trouble?			
Are you pregnant? If not when was your last period?			
Have you had blood transfusion?			
Do you take blood thinning medication?			

Have you ever been diagnosed or told you are positive for HIV (virus that causes AIDS)? Yes ☐ No ☐

Do you have any other illness or medical condition nor mentioned above (e.g. cancer, neurological, etc)? Yes ☐ No ☐

Have you ever been diagnosed with MRSA? Yes ☐ No ☐

Do you presently take any medications? If so, please provide a list the medications you take, the amount and frequency:

SEE MEDICATION/ALLERGY SHEET

Do you take vitamins, herbal medications, or herbal drinks? If so, include them on your list.

SEE MEDICATION/ALLERGY SHEET

Patient or guardian's signature: _____ Date _____.

Anesthesia Care Provider's (ACP) ASA: _____

Respiratory: Bi-laterally clear Yes ☐ No ☐ Other ☐

Cardiac: Regular Rate & Rhythm, No Significant Murmur Yes ☐ No ☐ Other ☐

_____

_____

_____

Anesthesia Care Provider's Signature: _____ Date:_____

I have reviewed the anesthesia- related and procedural risks on this patient for this procedure.

_____ _____

Supervising physician signature if indicated Date

PLACE PATIENT ID LABEL HERE

UPDATE OF CURRENT MEDICATIONS

Medication	Dosage (mg)	X per day	Condition for which prescribed

Patient Signature

Date

Sarasota Ambulatory Surgery Center, Ltd.

Sarasota Ambulatory Surgery Center is committed to provide you with quality customer service. Our commitment to serve means that we strive to provide quality service and overall satisfaction to all of our patients.

We need the same level of commitment from our patients; meaning that it is very important to keep your scheduled appointments and that you let us greater than 24 hours in advance if you are unable to keep the appointment. We understand that from time to time things happened that are out of control and we do take that into consideration.

Appointments not cancelled 24 hours in advance will be considered to be a no show and would be evaluated for a $50.00 charge after 2 missed appointments.

Patient Signature Date

Permission to Verbally Discuss Health Information

In limited cases, we may provide health information to family members, or close friends who are directly involved in your care or the payment for your health care, **unless you tell us not to**. For example, we may tell a friend who ask for you by name where you are in our facility and we may allow a friend or family member to pickup a prescription for you. We may also contact a family member if you have a serious injury or in other emergency circumstances. We may discuss medical information in the presence of a family member or friend **if you are also present and indicate that it is ok to do so.**

You can give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information **when you are not present**. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test result, treatment information and billing information. This does not mean that the person will have access to your medical records. Permission to disclose or release medical records is handled completely separate.

Complete this form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information. Here are some examples of when it may be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions.
- If a relative or friend is helping with billings questions.
- If a friend or relative calls to verify an appointment time.
- If a relative of friend comes in and asks if you are here and in or out of surgery or the procedure room.

If you change your mind when you have another appointment with us, you can complete a new permission form. You must notify us **IN WRITING.**

I give permission to the Surgery Center to VERBALLY discuss the following information about me
(*Check all boxes that apply*) with the following person(s)

Name: _____

Address: _____

Phone numbers: Work _____ Mobile _____ Home _____

- ☐ Appointment information.
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.
- ☐ Lab/test results.
- ☐ Billing and payment information.
- ☐ My location in the facility, whether I am waiting to go into surgery or procedure room, whether I am in a surgery or procedure room, whether I am in recovery, whether I have been released and discharged.

I understand that I have the right to revoke my permission at any time except where the Surgery Center has already made disclosures relying upon this permission request. **I understand I must notify the Surgery Center in writing if I want to revoke my permission.**

_____

Signature of Patient/Authorized Representative Date

PLACE RECORD ID STICKER

Sarasota Ambulatory Surgery Center

2821 Proctor Road
Sarasota, Fl 34231
941-870-1872

ADMISSION INSTRUCTIONS
FOR THE PATIENT HAVING SURGERY

The following instructions are for your safety. PLEASE adhere to them!!

1. DO NOT EAT OR DRINK any food or liquids (including water) after midnight on the night before surgery or as your doctor orders.

2. A DRESSING ROOM is available. Please wear loose, comfortable and warm clothing. A surgical facility is always kept at a cooler temperature than your home. Consider socks!

3. VALUABLES including jewelry, wigs and contact lens should be left at home. We can not be responsible for their safety.

4. COSMETICS should be minimal or not worn at all.

5. CONSENT FORMS, your signature will be required in accordance to your particular surgery. Please read carefully and be sure to clarify any question you may have regarding the surgery.

6. A RESPONSIBLE ADULT must accompany you to our facility and be available to take you home and assist you through the night.

7. ILLNESS in case of an obvious respiratory infection (cold) or any other acute illness within in one week prior to surgery, please contact your physician's office

8. LENGTH OF VISIT the approximate time you will be at the facility is 3 to 5 hours. This, of course can change with each individual and with physician's preference.

9. OTHER INSTRUCTIONS: If you normally take cardiac (heart) antihypertensive (blood pressure), bronchodilator (breathing) medication in the morning, then TAKE THESE MEDICATIONS AS SOON AS YOU GET UP ON THE DAY OF YOUR SURGERY, USING ONLY A SIP OF WATER. DO NO TAKE diuretics (water pills), aspirin or aspirin like medicines, or Coumadin on the day of surgery, unless you doctor instructed you.

   IF YOU NORMALLY TAKE INSULIN IN THE MORNING. DO NOT TAKE IT ON THE DAY OF SURGERY! Please bring your insulin vial with you.

DATE_____

_____ _____

PATIENT SIGNATURE WITNESS

SARASOTA AMBULATORY SURGERY CENTER
2821 PROCTOR ROAD
SARASOTA, FLORIDA 34231

WHAT WE ARE: We are an outpatient surgical and procedural facility licensed in the State of Florida

WHO WE ARE: We are wholly or partially owned by physicians who desired to provide a safe and comfortable medical facility that would provide efficient and effective services to patients.

YOUR RIGHTS AS A PATIENT: You have the right to choose the provider and the facility for your health care services. You will not be treated differently by your physician if you obtain health care services at another facility.

YOUR CHOICE: Your physician may have ownership interest in this facility. You have the right to know this, so if you want to know, please ask. Please discuss with your surgeon your questions or concerns, if you may want to have your procedure at an alternative health care facility.

CREDENTIALS: All of the physicians and anesthetists have been credentialed according to regulations and standards. Information is available upon request.

PATIENT GRIEVANCE: If patients have complaints or concerns in regard to care at our facility, they are encouraged to let the manager know. If further review is indicated, patients are urged to fill out a grievance form, which is available upon request at the front desk. Contact information for the Center manager, for the State and for Medicare are available below.

ADVANCE DIRECTIVES: If you have an advance directive or living will and a medical emergency arises, our surgery center will transfer you to the closest hospital. Sarasota Ambulatory Surgery Center will not follow do not resuscitate requests. Please discuss with your physician if you have questions. A hospital will make decisions about following any advance directive or living will or a request to not resuscitate should your heart stop or if you should stop breathing. You have a right to have your living will or advance directive information present in our medical record and to be informed of the facility's policy prior to the procedure. State information and forms to prepare an advance directive or living will, if you decide to have one, can be found at the following web site: Http://www.floridahealthfinder.gov/reports-guides/advance-directives.shtml
AHCA's Advance Directive form can be found at: www.fdhc.state.fl.us

Please let us know if you have a complaint or concern by asking for the Administrator.
Karrie Kintz, RN. Phone: 941-870-1872

Consumer Complaints can also be made at state and federal offices:

Write the State: Agency for health Care Administration, 2727 Mahan Drive, Tallahassee FL, 34308 1-888-419-3456

State web site: http://ahca.myflorida.com/Contract/call_center.shtml

Call the State: Complaint hotline at: 1-888-419-3456.

For Medicare Office of the Medicare Ombudsman at www.cms.hhs.gov/center/ombudsman.asp

PATIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. This statement of rights and responsibilities is posted in our facility in at least one location that is used by all patients.

Your rights and responsibilities include:

A patient, patient representative or surrogate has the *right* to

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient, patient representative or surrogate can understand.
- Be treated with respect, consideration and dignity.
- Be provided appropriate personal privacy.
- Have disclosures and records treated confidentially and be given the opportunity to approve or refuse record release except when release is required by law.
- Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect or harassment.
- Exercise his or her rights without being subject to discrimination or reprisal with impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Voice complaints and grievances, without reprisal.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Exercise of rights and respect for property and persons, including the right to
  - Voice grievances regarding treatment or care that is (or fails to be) furnished.
  - Be fully informed about a treatment or procedure and the expected outcome before it is performed.
  - Have a person appointed under State law to act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Refuse treatment to extent permitted by law and be informed of medical consequences of this action.
- Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- Have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- A prompt and reasonable response to questions and requests.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.

- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Know the facility policy on advance directives.
- Be informed of the names of physicians who have ownership in the facility.
- Have properly credentialed and qualified healthcare professionals providing patient care.

A patient, patient representative or surrogate is *responsible* for

- Providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, unless specifically exempted from this responsibility by his/her provider.
- Providing to the best of his or her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his or her health.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Following the treatment plan recommended by his health care provider.
- Be respectful of all the health providers and staff, as well as other patients.
- Providing a copy of information that you desire us to know about a durable power of attorney, health care surrogate, or other advance directive.
- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to his health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Keeping appointments.

COMPLAINTS

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Administrative Director at the surgery center. Or, you can call 941-870-1872.

We want to provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact the licensing agency of the state,
Agency for Health Care Administration
2727 Mahan Drive, Tallahassee, FL 32308
1-888-419-3456

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or on line at *http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html*.

The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help you need to understand your Medicare options and to apply your Medicare rights and protections.

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The ENTITY may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the ENTITY has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the ENTITY with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of all or a portion of the ENTITY and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes:

1. To remind you of your surgery date.
2. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that we provide and that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted without Authorization or Opportunity to Object.

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required or Permitted. We will disclose your protected health information when we are required or permitted to do so by any federal, state or local law. One situation in which we may disclose your protected health information is in the instance of a breach involving your protected health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to resolve the situation.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products; enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspected Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the ENTITY has a suspicion that your health condition was the
- Result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Once you have been dead for 50 years (or such other period as specified by law), we may use and disclose your health information without regard to the restrictions set forth in this notice. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. Under certain circumstances, your information may also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data use agreement.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the ENTITY to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. The ENTITY may release your health information to comply with worker's compensation laws or similar programs.

L. Business Associates. We may contract with one or more business associates through the course of our operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We required that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization. Examples of disclosures that require your authorization are:

A. Marketing. Except as otherwise permitted by law, we will not use or disclose your health information for marketing purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular product-specific good or service, we may also provide you with informational materials. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

B. No Sale of Your Health Information. We will not sell your health information to a third party without your prior written authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the ENTITY use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you request that the ENTITY not disclose your protected health information to your health plan for the purposes of payment or healthcare operations (but not treatment), and if you are paying for your treatment out of pocket in full, then the ENTITY must honor your requested restriction. Otherwise, the ENTITY is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the ENTITY does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how

Payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the ENTITY. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for an ENTITY directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment or health care operations using our electronic health record (if we have one for you). We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost-base fee.

F. The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The ENTITY is required by low to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the ENTITY changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact at your next visit. In the event there has been a breach of your unsecured protected health information, we will notify you.

VII. Complaints

You have the right to express complaints to the ENTITY and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the ENTITY by contacting the NTITY's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The ENTITY's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by the ENTITY you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer
Sarasota Ambulatory Surgery Center, Ltd. (ENTITY)
2821 Proctor Rd.
Sarasota, Fl 34235

Sarasota Ambulatory Surgery Center, Ltd. (ENTITY)

The Privacy Officer can be contacted by telephone at 941-870-1872

IX. Effective Date.

This Notice is effective April 14, 2003, with revisions effective February 17, 2010 and September, 2013.