SUBURBAN SURGICAL ASSOCIATES, LTD.
SUBURBAN METABOLIC INSTITUTE, LLC.

PATIENT PRIVACY PRACTICES

Patient Name:_____________________________________ Birth Date:__________________

1. **My medical care may be discussed with my: □ Significant Other □ Parent □ Children**

   List Names that apply:____

   ____

2. **Test results may be left on my answering machine/voicemail: □ Yes □ No**
3. **Appointment information may be left on answering machine/voicemail: □ Yes □ No**
4. **Medical Information may be emailed to me: □ Yes □ No**
5. **Preferred form of communication: □ Home Phone □ Cell Phone**

I,____ have received the Notice of Privacy
(Patient Signature)
Practices and the list of Office Policy and Procedures from SSA/SMI .

For personal representative of the patient *if patient is a minor or if the patient has a guardian to make their medical decisions.*

Print Name of personal representative:____

Relationship:____

Signature of personal representative: _______________________________________Date: