

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I hereby authorize the following individuals to obtain information regarding my health care and/or receive copies of my medical records:

Name

Relationship

I further authorize Regional Orthopaedic Health Care to furnish medical information to my insurance carriers necessary to process claims, my primary care physician and/or referring physician concerning my illness and treatment.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

Internal Use Only

If patient or patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____