AUTHORIZATION

Patient Name: _______________________ Date of Birth: ____________

Patient to complete the following: I authorize Orthopedic Specialists, PC to disclose information to and /or use the following people to help determine treatment for me: (Please list any family members or friends, such as your emergency contact person, that you would like to give us permission to communicate with.)

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This authorization is valid from _______________ and expires on ________________

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization. I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signed: ___________________________ Date: ___________________

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients: Federal law requires that we provide you with a copy of our Privacy Notice. The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice. If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on date listed.

Signed: _______________________________ Date: ___________________