

ORTHOPEDIC ASSOCIATES, LLC

Acknowledgment of our Notice of Privacy Practices

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Orthopedic Associates, LLC Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)

Date

Signature of patient or Personal Representative

Consent for Communication

As a patient of Orthopedic Associates, LLC, I am giving my consent to release medical information including test results, diagnosis, surgery scheduling and treatment dates to the following individuals:

Name

Relationship

Date

Name

Relationship

Date

Name

Relationship

Date

Additionally, I understand that this consent must be revoked in written form should I choose to do so.

Signature of Patient

Date