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**