



Privacy Notice Acknowledgement

Patient Name _____

Date of Birth: _____

Email: _____

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Privacy Notice for **Alliance Orthopaedics & Sports Medicine**.

If for some reason the facility needs to relay my protected medical information, i.e. test results, appointment information or billing issues, etc., you can either provide, leave or discuss the information with the following individual(s):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

I hereby authorize **Alliance Orthopaedics & Sports Medicine** to disclose the following protected health information.

- You may leave a message with detailed information on my answering machine at home.
- You may leave a message with detailed information on my voice mail at work.
- You may send me health & fitness information via email. Email address: _____

By signing below, I agree to the above mentioned statements.

Patient or Personal Representative Signature

Date

Printed Name of Patient or Personal Representative

Relation to Patient

ABOVE - Patient or Personal Representative Use Only

BELOW - Provider Use Only

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort was made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement was not obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement.
- Patient was unable to sign because of: _____
- There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- Other reason, described as: _____

Employee Signature

Date