St.Charles Orthopedics

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Description of Personal Representative's Authority	Date
Signature of Facility Representative	Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. St. Charles Orthopedics may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

	(Relationship to patient)
	(Relationship to patient)

I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine:	Tel. #
Office voicemail:	Tel. #
Other (specify):	Tel. #

Signature of Patient / Personal Representative Parent/Guardian	Date