

ORTHOPAEDIC SPECIALISTS, P.C.
Patient Consent for Purposes
of Treatment, Payment, Study and Healthcare Operations

By signing this form, I consent to the use or disclosure of my protected health information by **ORTHOPAEDIC SPECIALISTS, P.C.** for the purpose of providing treatment to me, obtaining payment, and for my health care bills or to conduct **ORTHOPAEDIC SPECIALISTS, P.C.** health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that **ORTHOPAEDIC SPECIALISTS, P.C.** has taken action in reliance on my prior consent.

I consent to using any of my post operative data for study purposes. I understand that any information used for a study will not include disclosure of my Private Health Information (PHI). My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me that has been created or received by **ORTHOPAEDIC SPECIALISTS, P.C.**, and that relates to my past, present or future physical or mental health or condition.

I understand I have a right to review **ORTHOPAEDIC SPECIALISTS, P.C.** Notice to Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of our health care operations including, but not limited to, post surgical studies in which any identifying patient information will be blinded and not disclosed. The Notice of Privacy Practices also describes my rights and **ORTHOPAEDIC SPECIALISTS, P.C.** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **ORTHOPAEDIC SPECIALISTS, P.C.** front office located at 3385 Dexter Court, Third Floor, Suite 300, Davenport, Iowa 52807 and on **ORTHOPAEDIC SPECIALISTS, P.C.** website at www.osquadcities.com.

ORTHOPAEDIC SPECIALISTS, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment, or accessing **ORTHOPAEDIC SPECIALISTS, P.C.** website.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or our healthcare operations. **ORTHOPAEDIC SPECIALISTS, P.C.** is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

I understand that diagnosis or treatment of me by **ORTHOPEdic SPECIALISTS, P.C.** may be conditioned upon my consent as evidenced by my signature on this document.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representatives Authority