Better experience. Better results.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of **Orthopaedic Specialists, P.C.'s** , Notice of Privacy Practices. 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 **Orthopaedic Specialists, P.C.'s** health care operations. The Notice of Privacy Practice also describes my rights and **Orthopaedic Specialists, P.C.'s** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the lobby of Orthopaedic Specialist, P.C. at 3385 Dexter Court, Third Floor, Suite 300, Davenport, Iowa and on **Orthopaedic Specialists, P.C.'s** website at www.osquadcities.com.

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

The following individual(s) may be given appointment times/dates and may also pickup prescriptions on my behalf.

Name	Phone	Relationship to Patient		Patient Signature
		_____ Spouse _____ Parent _____ Child _____ Other:		
		_____ Spouse _____ Parent _____ Child _____ Other:		

I fully understand that:

- The medical records and/or information that I have authorized to be disclosed hereunder are privileged, confidential and may only be disclosed with my authorization except as required by law.
- Only such records and/or information reasonably believed necessary are to be released and disclosed.
- Only records and/or information that were a result of tests, labs or procedures that were ordered by my physician at this office are eligible to be sent. Any other records that are part of my chart must be released from the ordering physician's office, unless absolutely deemed necessary by my physician at this office in an emergency situation.
- I may inspect and copy the records/ information that are to be disclosed prior to sending, unless my physician deems the information in them to be harmful to my mental well-being.
- I understand that this consent is revocable at any time prior to the release of information. This authorization will remain valid until revoked for any reason and/or authorized party changes.
- If I refuse to sign this authorization, my medical records/information will not be released to anyone unless a physician deems them necessary for my health and wellbeing.

______________________________ ________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative