

**Orthopedic Associates of Northern California  
Patient Acknowledgment of Receipt of Notice of Privacy Practices  
Patient Consent To Use & Disclose Protected Health Information**

I acknowledge that I have been provided for review a copy of Orthopedic Associates Notice of Privacy Practices that is available in the reception area. I will be offered a copy of any amended Notice of Privacy Practices in the future. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I consent to the use and disclosure of my individually identifiable health information by Orthopedic Associates for the purpose of providing treatment to me, receiving payment for health care services rendered, and/or engaging in health care operations. This includes calling my home and leaving a message or voice mail that will assist in carrying out the above mentioned items.

I have the right to request that Orthopedic Associates restrict how it uses or discloses my Protected Health Information. I further understand that the practice is not obligated to agree to my request. If Orthopedic Associates does agree to my request, the agreement will become binding.

I understand that I may revoke, in writing, the above consents at any time in the future.

**Signed:** \_\_\_\_\_ **Print:** \_\_\_\_\_

**Date:** \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- \_\_\_ parent or guardian of minor patient
- \_\_\_ guardian or conservator of an incompetent patient

Please list any individual(s) that you consent that our practice may discuss your health information, treatment, payment/billing questions and health care operations.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Name of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_