The Centers
for Advanced Orthopaedics

Notice of Privacy Practices Acknowledgment Form

Name of Patient (Print): _______________________________ Date of Birth: __________________

I acknowledge that I have received a copy of the Notice of Privacy Practices (the "Notice") for Centers for Advanced Orthopaedics, LLC. I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operation purposes.

In addition, I hereby give permission for this practice to disclose medical information and discuss my health care with the following person(s):

Name: _________________________________ Date: ___________________

Name: _________________________________ Date: ___________________

Signature: ____
(Patient or personal representative with appropriate legal authority)

Date: __________________________

If signed by a Personal Representative:

Print Name: ____

Relationship to Patient: _________________________________
(Parent, guardian, etc.)

--- OFFICE USE ONLY ---

If the Patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgment could not be obtained.

Notice of Privacy Practices given to the individual on _____________(date) **by:**

- ☐ Face to face meeting
- ☐ Other: ____

Reason Individual or Personal Representative did not sign this form:

- ☐ Patient or Personal Representative chose not to sign
- ☐ Other: ____