HIPAA PRIVACY NOTICE CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government of regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

I understand and have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Performance Orthopaedics & Sports Medicine which more fully describes the uses and disclosures. I understand that Performance Orthopaedics & Sports Medicine has the right to change its privacy policies and that I can receive such changed notices upon request. By signing this form I acknowledge that I have been afforded the opportunity to consider Performance Orthopaedics & Sports Medicine's Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

_____ _____

Signature of Patient or Legally Authorized Representative Date

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION

Indicated below are names of any Person(s) to whom I would like Performance Orthopaedics & Sports Medicine to allow disclosure of Protected Health Information (PHI). (Please specify the type of information that may be disclosed, such as lab/imaging test, appointment information, prescription information, bill information, etc. You may indicate "All" if appropriate). I understand that I am not required to list anyone and I may change this list at any time in writing.

Name	Relationship	Phone number	Type of Information

Authorized person(s) to pick up prescriptions: Medical information is not released to this person. (However this person can be the same as your HIPAA Authorized Contact)

_____ _____

Person Authorized to pick up prescription Relationship to patient

_____ _____

Person Authorized to pick up prescription Relationship to patient

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

Printed Name of Patient:_____

_____ _____

Signature of Patient or Legally Authorized Representative Date