Pediatrics

ACKNOWLEDGEMENT OF DISCLOSURE OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices provided to me by Liljenquist & Redd Orthopedic Surgery. LROS and I have been given the opportunity to discuss the privacy practices at LROS. I understand that the practice may, at its discretion, change the term and conditions of this notice. Any questions I may have been answered to m satisfaction. I understand the content of this Notice of Privacy. I have been provided with a copy of the same.

X Signature: ____ Date: ____________________

Minor's Name(Print): ______________________________________ DOB: ____________________

I authorize Liljenquist & Redd Orthopedics Surgery to release the following healthcare information to the following individuals

(Please check on of the following):

My complete health record
To schedule, change, and verify my appointments
Any billing correspondents

____ Relationship: __________________________

____ Relationship: __________________________

____ Relationship: __________________________

Information is **NOT** to be released to anyone.

Please list any specific restrictions: ____

I understand that my records are protected by; The Health Insurance Portability and Accountability Act (HIPPA), and cannot be disclosed without my written consent unless it is provide a continuity of care. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X ____________________________ Print Name: ___________________________ Date: ___________________

The notice of Privacy Practices was provided to __________________________ , however, he/she did not acknowledge receipt for the following reason: refused, did not understand, other.

Staff Signature: Date: