ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Basin Orthopedic Surgical Specialists, P.A. Notice of Privacy Practices.

_____ Date:_____
Signature of Patient (Parent/Guardian if a Minor)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign

_____ Emergency situation kept us from obtaining the patient's signature

_____ Other _____

I hereby authorize **Basin Orthopedic Surgical Specialists, P.A.** to release healthcare information on my behalf to the person(s) listed below (e.g. Family member, friend, etc.)

Name: _____ DOB:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relationship: _____

This request and authorization applies to:

☐ Healthcare Information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES IN 12 MONTHS AFTER IT IS SIGNED