

Name: _____

Chart: _____

DOB: _____

JEWETT ORTHOPAEDIC CLINIC, PA
Notice of Privacy Practices Acknowledgment Form
Consent to Use or Disclose Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting any Jewett Orthopaedic Clinic Supervisor. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. **Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health Information), if you allow a third party other than one of the practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Jewett Orthopaedic Clinic may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I have read and understand the information in this acknowledgment. I am the patient or am authorized to act on behalf of the patient to sign this document. By signing below, I acknowledge and agree to the above conditions.

Print name of patient (or authorized representative)

Signature of patient (or authorized representative)

Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient