Notice of Privacy Practices

The **Notice of Privacy Practice** tells you how we may use and share your medical information. It also describes your rights with respect to your medical information.

- We will use your medical information for treatment and for payment.
- We will use your medical information for health care operations.
- We may use your medical information for any uses that are required/permitted by law.

I understand that the HIPAA Notice of Privacy Practices is available at my APOrtho physician's office for my review.

As indicated by my signature below I hereby acknowledge receipt and understanding of the *Notice of Privacy Practices.*

_____ _____
Signature of Patient or Responsible Representative Date

_____
Printed name of Patient or Responsible Representative

_____
Description of Personal Representative's Authority to Act on Patient's Behalf

Contact and Phone Message Authorization

Do the physicians and staff of APOrtho have your permission to leave messages containing medical and/or financial information on an **answering machine/voice mail**?
**Appointment Reminders may be left on your answering machine/voice mail if you answer no.

At Home □ Yes □ No Phone Number: _____

At Work □ Yes □ No Phone Number: _____

On Cell □ Yes □ No Phone Number: _____

I give authorization to the doctors or staff at APOrtho to discuss my medical and/or financial information with the following people:

	Name	Relationship	Phone Number
(1)	_____	_____	_____
(2)	_____	_____	_____

I understand it is my responsibility to inform APOrtho of any desired changes in this authorization.

Signature: _____ Date: _____

Revised 7/2015