ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered Summit Orthopaedic Home Care's Notice of Privacy Practices.

_____I have received a copy of the Notice of Privacy Practices.

_____I do not wish to receive a copy of the Notice of Privacy Practices.

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_____
Patient Name

_____ _____
Signature Date

_____
Printed Name of Person Acknowledging Receipt (if other than the patient) and Relationship to Patient

COMMUNICATION PREFRENCES REGARDING PHI

To assist in your care, it may be necessary to release our ***Protected Health Information*** to someone other than yourself. To whom may we talk?

Yes No

Spouse_____

Parent_____

Step-Parent_____

Other Person(s)_____

May we leave a message on:

Yes No

Your answering machine/voice mail.

Preferred Phone Number _____ (circle one: home/work/mobile/other).

_____
Patient Name

_____ _____
Signature Date

_____
Printed Name of Person Acknowledging Receipt (if other than the patient) and Relationship to Patient