ADVANCED ORTHOPAEDIC SPECIALISTS

Sports Medicine–Arthroscopic–Joint Reconstruction

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____, have received a copy of Advance Orthopaedic Specialists' Notice of Privacy Practices.

I hereby authorize Arnold & Cox Knee and Shoulder Center to give the following people information concerning my health and well being, regarding appointment times, test/lab results, medications, procedures, and any other information regarding my health.

__Spouse **Name: _____**

__Significant Other **Name: _____**

__A Specified Person **Name: _____**
(Name and Relationship)

Name: _____
(Name and Relationship)

__ I give permission to leave a message on my home answering machine or work voice mail.

__I understand there will be a fee of $5 for the first 5 pages and $0.25 per page thereafter for records requested by the patient.

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

_____ _____

Signature of Patient or Guardian **Date**