Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

Patient Name: _____

Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices (HIPAA information). This notice provides a complete description of the uses and disclosures of my health information.

Signature: _____ **Date**: _____

If person signing form is not the patient, please print your name and list relationship to patient:

Name _____ ***Relationship*** _____