OSC
Premier Bone and Joint Surgeons
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www.orthospecialtyclinic.com

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use of my protected health information by OSC for the purpose of diagnosing or providing treatment to me, obtaining payment form my health care bills or to conduct health care operations of OSC.

I have the right to revoke this consent, in writing, at any time, except to the extent that OSC has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices (NPP) for OSC prior to signing this document. The NPP has been provided to me. The NPP describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of OSC. The NPP for OSC is also provided at the front desk or on our website at www.orthospecialtyclinic.com. The NPP also describes my rights and OSC's duties with respect to my protected health information.

Electronic Format: I acknowledge that my records are stored in an electronic format. I understand OSC maintains their patient records, with the exception of actual radiographic films, in electronic format only. Original documents are destroyed after being converted to electronic format.

OSC reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by accessing OSC's website, calling the office, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices (NPP).

Release of information: I hereby give OSC permission to release information on my medical condition to the following people:

_____
Name & Relationship

I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

_____ _____
Signature of Patient or Patients Representative Date

_____
Name of Patient or Patients Representative

_____
Description of Personal Representatives Authority

****I would like to Restrict disclosers "To the Insurance Company" for services paid for out of pocket.**

Date of Service: _____ Patient Signature: _____

FOR OFFICE USE ONLY

Patient or Personal Representative refused to sign acknowledgment
OSC Staff: _____ Date _____