



**THIS IS AN EXPLANATION FOR THE HIPAA PRIVACY ACT  
IMPORTANT PLEASE READ**

This is not a release for medical records.

On your patient information form you will be asked to list anyone who would call to confirm appointments or inquire about billing information for you. This would include: a spouse, a caregiver, or any other immediate family member. If someone calls for you and you did not list his or her name on the form, WE ARE NOT ALLOWED TO GIVE THEM ANY INFORMATION. We apologize for any inconvenience that this may cause but we are bound by the HIPAA Law and gladly abide by it for your protection.

**Note: If you are a parent of a minor patient being seen here, your name needs to be on the HIPAA form. If it is not, WE ARE NOT ALLOWED TO GIVE YOU ANY INFORMATION.**

**CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS**

By signing below, you hereby consent for Orthopedic & Sports Medicine Specialists to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

The Notice of Privacy Practices for PHI are available upon request, and you may always get a current copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to requested restrictions, however; if the practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

**PLEASE PRINT NAME AND PHONE NUMBER**

**You may communicate with the following individuals regarding my condition or course of treatment.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Individual Signature

\_\_\_\_\_  
Date

You agree, in order for us to service your account or to collect monies you may owe, Orthopedic and Sports Medicine Specialists, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Orthopedic and Sports Medicine Specialists, PC, its employees and/or agents may contact me/us as described above.

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date