Receipt of Notice of Privacy Practices:

I have been given the Notice of Privacy Practices and hereby acknowledge that I have read and understand the privacy practices of New West Sports Medicine & Orthopaedic Surgery.

_____

Patient Name

_____

Signature of Patient or Legal Representative (if patient is a minor or unable to sign)

_____

Date

_____

Relationship of Legal Representative to the Patient (if needed)

Authorization to Discuss and Disclose Medical Information:

I hereby authorize New West Sports Medicine & Orthopaedic Surgery to discuss and disclose the following information from my health record:

- Office visit notes
- Operative reports
- Medical imaging reports
- Billing records

This information can be discussed or released to the following people (list name and date of birth):

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

This authorization may be revoked in writing at any time, but all action taken in reliance to the authorization before the time of revocation remains acceptable and valid. Unless otherwise revoked, this authorization will expire one year from the date signed below.

_____

Signature of Patient or Legal Representative (if patient is a minor or unable to sign)

_____

Date

_____

Relationship of Legal Representative to the Patient (if needed)