ORTHOPAEDICS NEW ENDLAND, P.C.

Name: ________________________________ Date: ______________________

HIPAA RELEASE

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

Name	Relation	Telephone #
Name	Relation	Telephone #
Name	Relation	Telephone #

Dear Patient:

Under the new Federal Health Care Law of 2011, we have been asked to request the following information from you.

Email address: _______________________________Birth Order: ________________
(ex. 1st born of 6)

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ ________________________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_______________ Attempt:____

Staff Name:___________________________________