ORTHOPAEDIC SURGERY

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PONTCHARTRAIN
Bone & Joint Clinic

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KURT W. SCHLOTTERER
Administrator

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, hereby acknowledge and agree that I have received a copy of Pontchartrain Bone & Joint Clinic's Notice of Privacy Information Practices.

_____ _____

Signature Patient's legal representative (If applicable)

_____

Date

Official use only

Pontchartrain Bone & Joint Clinic has made good faith efforts to attain the above referenced acknowledgement of receipt of the Notice of Privacy Information Practices but is unable to obtain the acknowledgement of receipt. The reason(s) are as follows:

_____

_____

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

__ I GIVE PERMISSION for Pontchartrain Bone & Joint Clinic to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____