MUIR ORTHOPAEDIC SPECIALISTS

SPECIALIZED • INNOVATIVE • COMPASSIONATE

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have received a copy of the MOS Notice of Privacy Practices. I understand that MOS has the right to change its Notice of Privacy Practices from time to time and that I may contact MOS at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of Patient/Guardian: _____ Date: _____

Relationship to Patient: _____ Patient's Date of Birth:_____

Protected Health Information (PHI) Release Authorization

Persons who are involved in your care (spouse, children, friends, etc.) may inquire about your treatment, appointments, lab results, prescriptions, billing, medical records, x-rays, etc. Please list the individuals who we may share your PHI with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

*** * Please note that MOS will only release PHI to the individuals listed above * ***

I, _____, acknowledge in signing this document that I am giving Muir Orthopaedic Specialists authorization to release or discuss PHI either in writing or verbally to the person(s) specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing to the address listed below. A copy of this will be placed in my records at Muir Orthopaedic Specialists.

Signature of Patient/Guardian: _____ Date: _____

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