Orthopedics New England
Dedication. Compassion. Experience.

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Receipt of Notice of Privacy Practices Acknowledgement

By signing this form I acknowledge the receipt of Orthopedics New England's Notice of Privacy Practices which provides me with detailed information about how Orthopedics New England may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I also understand that if Orthopedics New England amends its Notice of Privacy Practices, I will be informed of the change and may obtain a copy of the revised Notice by contacting the office, at (508) 655-0471, for a revised copy or by downloading the most recent version from the link on our webpage at http://www.orthopedicsne.com/about/privacy-security.

I have a right to request, in writing, that Orthopedics New England restricts how they use and disclose my protected health information for the purposes of treatment, payment or health care operations and that the practice is not required by law to grant my request. However, if the practice does decide to grant my request the practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

Patient's Signature:_____ Date:_____

Printed Patient Name:_____ Date of Birth:_____

Signature of Legal Representative:_____

Printed Name:_____ Date:_____

Relationship of Representative to Patient:_____

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