LILJENQUIST, OLSON & REDD
ORTHOPEDIC SURGERY

ACKNOWLEDGEMENT OF DISCLOSURE OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices provided to me by Liljenquist & Redd Orthopedic Surgery. LROS and I have been given the opportunity to discuss the privacy practices at LROS. I understand that the practice may, at its discretion, change the terms and conditions of this notice. Any questions I may have been answered to my satisfaction. I understand the content of this Notice of Privacy. I have been provided with a copy of the same.

I authorize LROS to release the following healthcare information to the following individuals:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

(Please check one of the following):

- ☐ My complete health record.
- ☐ To schedule, change, and verify my appointments.
- ☐ Any billing correspondents

Please list any specific restrictions: _____

☐ **My information is <u>NOT</u> to be released to anyone.**

I understand that my records are protected by; The Health Insurance Portability and Accountability Act (HIPPA) and cannot be disclosed without my written consent unless it is providing a continuity of care. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X _____ Print Name: _____ Date: _____