

ACKNOWLEDGEMENT OF PRIVACY NOTICE

Tri-City Orthopaedic Clinic has available for your review the **NOTICE OF PRIVACY POLICIES**, detailing how your information may be used and disclosed as permitted under federal and state law.

I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witness by:** _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____