PRECISION ORTHOPAEDICS, SC
KYLE SHEPPERSON, MD

Acknowledgment/Consent
Receipt of Privacy Practice
Precision Orthopaedics, SC

Patient Name: _____ Date: _____

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* from Precision Orthopaedics.

Protected Health Information (PHI) Precision Orthopaedics HIPAA consent allows us to communicate with immediate family members, other healthcare professionals or healthcare facilities to assist you in your health care.

Unless you object, we may use or disclose your protected heath information to notify, or assist in notifying, a family member, personal representative, healthcare professional or other healthcare facility or other person responsible for your care, about your location, and about your general condition, or your health.

Communication with Family/Personal Care Representative/Guardian
Using your best judgment, we may disclose to immediate family members, or other relatives, or a close personal friend, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. This information may be in written form or by telephone.

You may identify specific individual(s) that we may share medical information with verbally, in writing or by phone:

_____

_____

Specific description of the information to be used or disclosed, including the specific purpose:

_____

_____

Please complete the information below:
_____ I authorize you to share medical information as indicated above.
_____ I **DO NOT** authorize you to share medical information as indicated above.

Signed: _____ Date: _____

Office Staff: _____ Date: _____

***This disclosure will not expire unless we are notified. You may contact our office to change your protected health information at any time.**