

**Grand Haven Bone & Joint
1445 Sheldon G-1
Grand Haven, MI 49417**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand I do not have to possess a copy of the *Notice of Privacy Practices* but that I was offered the opportunity to obtain a copy of this document.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Signature of Patient (or Legal Guardian) _____ Date: _____

Patient Name, (printed) _____ Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this NPP Acknowledgement but was unable to do so as documented below:

Date: Initials: Reason:

Patient Consent for Use and Disclosure of Protected Health Information

I give my consent for Grand Haven Bone & Joint to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, Grand Haven Bone & Joint may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including x-ray and lab results among others.

With this consent Grand Haven Bone & Joint may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Grand Haven Bone & Joint may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Grand Haven Bone & Joint restrict how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Grand Haven Bone & Joint may decline to provide treatment to me.

Signature of Patient (or Legal Guardian) _____ Date: _____

Patient Name, (printed) _____ Relationship to Patient: _____

