Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice for **Resurgens Orthopaedics.**

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative's Name Printed   Patient or Personal Representative's Signature   Patient's Date of Birth

Personal Representative's Relation to Patient   Date

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Summary Privacy Notice. However, acknowledgement has not been obtained because:

- ❑ Patient refused to sign the Summary Privacy Notice Acknowledgement.
- ❑ Patient was unable because: ______
- ❑ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- ❑ Other reason, describe below: ______

Employee's Name Printed   Employee's Signature   Date

Authorization to Release Protected Health Information

I, ______, hereby authorize Resurgens Orthopaedics to release my protected health information to the following: *(Please check and provide the name or specific entities to whom your protected health information may be given.)*

______ Family members or friends: ______

______ School or Employer: ______

______ Other: ______

Patient or Personal Representative's Name Printed   Patient or Personal Representative's Signature   Date

There may be instances that your health care provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Resurgens cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Resurgens Orthopaedics to communicate my PHI electronically.

☐ **Yes**   ☐ **No**

This authorization shall be in effect *(please check one)*.

______ no expiration date

______ expiration date of ______

Patient or Personal Representative's Name Printed   Patient or Personal Representative's Signature   Date