

## Spine & Orthopedic Center OF N.J., LLC.

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Fellow-American Academy of Orthopedic Surgeons  
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PATIENT NAME: \_\_\_\_\_

### Acknowledgement of Receipt of Notice of Privacy Practices (To be filed in Patient's Medical Record)

I acknowledge receipt of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: X \_\_\_\_\_ Date: \_\_\_\_\_

I do not wish the office to release medical information.

I do wish the office to release medical information to the following person(s) :

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Any exceptions of medical records release: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_