SPINE & ORTHOPEDIC CENTER OF N.J., LLC

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Fellow American Academy of Orthopedic Surgeons
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PATIENT NAME: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(TO BE FILED IN PATIENT'S MEDICAL RECORDS)

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: _____ 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'S SIGNATURE DATE