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

90 Sparta Avenue, Sparta, NJ 07871 (973) 726-9500 -- (973) 726-8218

DAVID B. BASCH, MD., FAAOS
Fellow-American Academy of Orthopedic Surgeons
Diplomat American Board of Orthopedic Surgery

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: _____

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