FAIR OAKS ORTHOPAEDIC ASSOCIATES

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name:				
Patient Account # : Date of Registration:				
Date of Registration.				
By signing this form, you acknowled has provided you access to a copy how your health information will be required to have you sign this form	y of its HIPAA e handled in v	A Privacy Not various situat	ice, which e	xplains
If your first date of service with us provide you access to this notice after the emergency.		• •		•
Please specify by checking the aprelated information (e.g., lab/radio patient communications) with/on:				
Home Answering Ma	achine	Yes	No	
Work Voicemail		Yes	No	
Personal/Work Ema		Yes	No	
Provide Email Addre Cell Phone	ess:	Yes	No	
Relative or Other Pe	rson Livina V		Yes	No
Please note that if the above se we have your approval to conta [] The Practice has provided managed that I have read,	ct you using ne with a cop	any one of by of its Priva	these meth acy Notice.	ods.
[] I have read the Privacy Notice		_		
Patient's/Guardian Signature			Date	
FOR PRACTICE STAFF TO COMNOT SIGNED:	IPLETE IF A	CKNOWLED	GEMENT F	ORM
 Does patient have a copy of th Please explain why the patient and the Practice's efforts in trying 	was unable t	o sign an acl	knowledgem	No ent form
Employee's Initials	Date	_		