ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

AUTHORIZED PATIENT NOTIFICATION LIST

REQUIRED OF HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C. ("ESMOS") to: conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment, directly or indirectly; obtain payment from Medicare and third-party payers; and conduct normal healthcare operations such as quality assessments and physician certifications.

DESIGNATION OF DISCLOSURE

I agree that ESMOS may disclose my protected health information to a family member, close personal friend, or other caregiver, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, ESMOS will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare, unless I request otherwise. I understand that for uses and disclosures to individuals or entities that require an authorization pursuant to HIPAA, ESMOS will provide me with a HIPAA-compliant authorization form for my completion.

I designate the following person(s) listed below as a person (or persons) involved with my healthcare and/or payment:

NAME	RELATIONSHIP	NUMBER
NAME	RELATIONSHIP	NUMBER

○ I do not want to designate anyone to have authorization at this time.

CONTACT INFORMATION

I wish to be contacted in the following manner (Please check all that apply):

○ CELL PHONE ○ WORK PHONE ○ EMAIL ADDRESS	
OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION ○ YES ○ NO	
LEAVE A MESSAGE WITH A CALL BACK NUMBER ONLY ○ YES ○ NO	
OK TO MAIL TO MY HOME ○ YES ○ NO	OK TO MAIL TO MY WORK ○ YES ○ NO
OK TO FAX ○ YES ○ NO (INCLUDE NUMBER IF "YES").	

cont'd.

ACKNOWLEDGEMENT AND AGREEMENT TO THE TERMS AND CONDITIONS OF THIS DOCUMENT:

PATIENT'S NAME	SIGNATURE	DATE
PARENT/GUARDIAN NAME (IF APPLICABLE)	SIGNATURE	DATE

This document will be part of your permanent record. In the event that any selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed, or added to the Authorized Notification List.