ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Tri-State Orthopedics **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restrictions:

_____
_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ Date:_____

If not signed by the patient, please indicate relationship to the patient (e.g., Parent)

Relationship:_____ Witnessed by:_____

If the patient refuses to sign indicate your attempt to obtain a signature below:

( ) Patient refuses to sign Acknowledgement form.
Date:_____
Time:_____
Employee Name:_____