# Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Hartford Orthopedic Surgeons, P.C. ("HOS") to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by HOS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how HOS will use and disclose my information can be found in HOS's Notice of Privacy Practices. I understand that this consent is effective for as long as HOS maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received HOS's Notice of Privacy Practices currently in effect.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence or other medical reason
- ☐ Other: _____