HARTFORD ORTHOPEDIC SURGEONS PC | ORTHO SPEEDPASS Walk-In Urgent Orthopedic Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) our responsibilities for maintaining the privacy of your PHI; (3) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; and (4) your rights to complain if you believe your privacy rights have been violated. Hartford Orthopedic Surgeons complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Hartford Orthopedic Surgeons provides equal access to all persons, including those who have Limited English Proficiency (LEP), those who are deaf, hard of hearing, visually impaired or have other special communication needs.

- I acknowledge that I have read the foregoing and am aware of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I acknowledge that Hartford Orthopedic Surgeons, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions in writing on the use and disclosure of my PHI if I so choose.

Printed Name of Patient: _____

Signature of Patient/Guardian: _____ **Date:** _____

Printed Name of Guardian: _____ Relationship: _____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Hartford Orthopedic Surgeons to disclose your PHI to the following individuals:

Name: _____

Relationship to Patient: _____Telephone: _____

Name: _____

Relationship to Patient: _____Telephone: _____

Signature of Patient/Guardian: _____ **Date:** _____