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 based on 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 my Protected Health Information, including prescription history, with other health care professionals to treat me, coordinate my care, and/or 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:** _____/_____/_____

PHI DISCLOSURE TO FAMILY MEMBERS

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

Name(s): _____**Relationship:** _____ **Telephone:** _____

Name(s): _____**Relationship:** _____ **Telephone:** _____

Consent for Medical Treatment

I hereby voluntarily consent to outpatient care from Hartford Orthopedic Surgeons health care providers encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work, x-rays, and administration of medications as prescribed by the providers.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I understand that during treatment, medical providers and staff may be inadvertently exposed to my blood and/or body fluids and if so, I agree to testing of myself to promote the health and welfare of the health care worker.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

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

☐ **Patient under 18 years of age**

☐ **Patient unable to sign.**

Child: _____ **Date of Birth:** _____/_____/_____