University Orthopedic and Joint Replacement Center
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (effective 9/23/2013)

I acknowledge that I have been given the opportunity to read a copy of this practice's Notice of Privacy Practices (NPP) which describes in detail the uses and disclosures that may be made of my protected health information (PHI) and describes my rights and this practice's responsibilities with respect to my PHI. I acknowledge that the practice's NPP includes but is not limited to:

- A statement that the practice is required by law to maintain the privacy of PHI
- A statement that the practice is required to abide by the terms of the NPP currently in effect
- A description of uses and disclosures the practice is permitted to make of my PHI without my consent or authorization
- A description of other uses and disclosures of my PHI that will be made only with my written authorization and a statement advising that I may revoke such authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- Descriptions of my rights with regard to PHI and how I may exercise them, including:
    - The right to complain to the practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory action will be taken against me in the event of such a complaint
    - The right to request restriction on certain uses and disclosures of my PHI, that this practice is not required to agree to my request, but if it does it must abide by it
    - The right to receive confidential communication of my PHI by a method I specify
    - The right to inspect and receive a copy of my PHI
    - The right to request an amendment of my PHI
    - The right to request and receive an accounting of non-standard disclosures of my PHI
    - The right to obtain a paper copy of the practice's NPP upon request

I acknowledge that this practice reserves the right to change its NPP, that I will be offered a copy of any revised NPP at the time of my first visit after the revision becomes effective, and that I can request a copy of the practice's current NPP at any time.

My signature below acknowledges that I have been given the opportunity to read the Notice of Privacy Practice (NPP).

Name of Patient _____ Signature of patient or responsible party _____ Date _____

Relationship to Patient (if signed by patient's personal representative)_____

ADDITIONAL DISCLOSURE AUTHORIZATION: **IMPORTANT: no PHI will be given to anyone unless they are listed here. Verbal authorization is not permitted.
I hereby specifically authorize disclosure of my PHI to the following individuals:

Name _____ relationship to patient

Name _____ relationship to patient

OFFICE USE ONLY: I attempted to obtain patient's signature but was unable to do so as documented below:
Date:_____ Initials:_____ Reason:_____
(e.g.: refused to sign / communication barrier / emergency situation / other specific reason)