Patient ID#: _____

NWIA Bone, Joint & Sports Surgeons

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Health Insurance Portability and Accountability Act of 1996 NWIA Bone, Joint & Sports Surgeons may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information as described in the above Notice of Privacy Practices. If you would like a copy of our "Notice of Privacy Practices" please ask our receptionist when you check in for your appointment.

I, _____ hereby authorizes the use and/or disclosure for the purpose of carrying out treatment, payment or health care operation.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by giving written notice to NWIA Bone, Joint & Sports Surgeons. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I further understand that my ability to obtain treatment, my eligibility for benefits, et cetera, will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I acknowledge that a copy of NWIA Bone, Joint & Sports Surgeons Notice of Privacy Practices was made available to me and/or I received a copy and understand how the practice may use and disclose my confidential information. I further understand that the physician has reserved a right to change his privacy practices that are described in the Notice of Privacy Practices and a copy will be made available to me of the revision.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Signed form received by: _____

Reason acknowledgment refused: _____