SOUTHLAND
– ORTHOPAEDICS –

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PATIENT CONSENT FORM

☐ I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed the *Notice of Privacy Practices* containing a more complete description about the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Southland Orthopaedics has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

HIPPA DISCLOSURE AUTHORIZATION

☐ I authorize Southland Orthopaedics to speak with and disclose information about my medical conditions to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, further authorize Southland Orthopaedics to contact me and leave messages on:

Home Phone: _____ Cell phone: _____

Email: _____

This authorization will remain in place until rescinded by me.

_____ _____
Patient Name Patient Signature

Date: _____