NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE

18111 Brookhurst St. Suite 2600 Fountain Valley, CA 92708

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide to such restrictions.

Patient Name: _____

Patient Representative:_____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" for CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, but was unable to do so, as documented below.

Date: _____ **Initials:** _____ **Reason:** _____