MICHIGAN STREET ORTHOPEDIC SPECIALISTS, P. C.

Bereza • Lovell • Ugolini

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) requires this office to comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA’s requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosure any of your information except for our disclosures in connection with; a defense to a claim challenging our professional competence, a review entity’s functions, a claim for payment of fees, a third party payer’s examination of our records, a court order as part of a criminal investigation, an identification of a dead body, a licensure investigation, or a child abuse/neglect investigation.

From time to time it may be necessary for us to make decisions of your information in connection with your treatment. For example, we may make a referral to or consult with another doctor or other health care professional, provide a specimen to a laboratory for testing or other wise make disclosure of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below to acknowledge that you have received a copy of our Notice of Privacy Practices.

X____ ____

Patient Signature (if a minor, parent or guardian signature) **Patient Name (please print name)**

____

Date

Patient Consent

Please sign this form to consent to disclose any of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X____ ____

Patient Signature (if a minor, parent or guardian signature) **Patient Name (please print name)**

____

Date

Is there anyone you **do not want** health information released to:

____

____

For office use only: Patient refused to sign – The following circumstances prohibited the patient from signing the acknowledgement:

____

____________________________ ____________________________ ______________________

Office Personnel (signature) **Office Personnel (print name)** **Date**

X Please initial that you have reviewed this document.

2008 _______ 2009 _______ 2010 _______ 2011 _______ 2012 _______ 2013 _______ 2014 _______ 2015 ______