



### Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice for **Resurgens Orthopaedics**.

Privacy Notice Revision Date: April 14, 2003

\_\_\_\_\_  
Patient or Personal Representative's Name Printed

\_\_\_\_\_  
Patient or Personal Representative's Name Signature

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Personal Representative's Relation to Patient

\_\_\_\_\_  
Date

### Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Summary Privacy Notice. However, acknowledgement has not been obtained because:

Patient refused to sign the Summary Privacy Notice Acknowledgement.

Patient was unable because:

\_\_\_\_\_

There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

Other reason, describe below: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee's Name Printed

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

### Authorization to Release Protected Health Information

I, \_\_\_\_\_, hereby authorize Resurgens Orthopaedics to release my protected health information to the following: *(Please check and provide the name or specific entities to whom your protected health information may be given.)*

\_\_\_\_\_ Family members or friends: \_\_\_\_\_

\_\_\_\_\_ School or Employer: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Patient or Personal Representative's Name Printed

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Date

**There may be instances that your health care provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Resurgens cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Resurgens Orthopaedics to communicate my PHI electronically.**

Yes       No

This authorization shall be in effect *(please check one)*.

\_\_\_\_\_ no expiration date

\_\_\_\_\_ expiration date of \_\_\_\_\_

\_\_\_\_\_  
Patient or Personal Representative's Name Printed

\_\_\_\_\_  
Patient or Personal Representative's Name Signature

\_\_\_\_\_  
Date