



PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that the Resurgens Privacy Notice Revision Date, August 15, 2011 has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also displayed in the waiting room and on the Resurgens' website www.resurgens.com.

Patient or Personal Representative's Name Printed **X** _____
Patient or Personal Representative's Signature Patient's Date of Birth

Personal Representative's Relation to Patient Date

Documentation of Good Faith Effort

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

- Patient refused to sign the 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: _____

Employee's Name Printed Employee's Signature Date

Authorization to Release Protected Health Information

I, _____, hereby authorized Resurgens Orthopaedics to release my protected health information to the following: (Please check and provide the NAME or specific entities to which your protected health information may be given.)

- Family members or friends :(please give names) _____
- School or Employer: (list names of school/employer) _____
- Other: _____

Patient or Personal Representative's Name Printed **X** _____
Patient or Personal Representative's Signature Date

There may be instances that your healthcare provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another healthcare 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 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 **X** _____
Patient or Personal Representative's Signature Date