

SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

516 BROOKWOOD BOULEVARD

BIRMINGHAM, ALABAMA 35209

Phone: (205) 397-2663/ Fax: (205)278-0049

Patient Name: _____ Date of Birth: _____
Patient Address: _____ SSN: _____

I authorize Southern Orthopaedic Specialists, P.C. to discuss my medical information with the following:

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Parents _____ |
| <input type="checkbox"/> Spouse _____ | <input type="checkbox"/> Mother (only) _____ |
| <input type="checkbox"/> Father (only) _____ | <input type="checkbox"/> Guardian _____ |
| <input type="checkbox"/> Other _____ | , relationship to patient _____ |

I wish to be contacted by Southern Orthopaedic Specialists, P.C. in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> Okay to leave a message with detailed information
<input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> Okay to mail to my home address
<input type="checkbox"/> Okay to mail to my work address
<input type="checkbox"/> Okay to fax to this number _____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> Okay to leave a message with detailed information
<input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Other (email address) _____

_____ |

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGEMENTS:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Southern Orthopaedic Specialists, P.C.

Signature of Patient or Personal Representative

Date

Personal Representative's relationship to the Patient

Signature of Witness

PRINT Personal Representative's Name

