SPINE & ORTHOPEDIC CENTER OF N.J., LLC

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Fellow American Academy of Orthopedic Surgeons
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PATIENT NAME: ____

Acknowledgement of Receipt of Notice of Privacy Practices
(To be filed in Patient's Medical Record)

I acknowledge receipt of the Notice of Privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature: ______________________________ Date: ____________________

____ I do **not** wish the office to release medical information.

____ I **do** wish the office to release medical information to the following person(s):

Name: ____________________________________

Relationship to patient: ________________________

Name: ____________________________________

Relationship to patient: ________________________

Any exceptions of medical records release: ___________________________________

Patient Signature: ___________________________________ Date: ____________