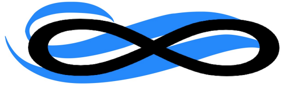

PRIVACY POLICY AND INFORMATION

	APPOINTMENT INFORMATION		MEDICAL INFORMATION	
	PLEASE CIRCLE RESPONSE			
HOME PHONE/VOICEMAIL	YES	NO	YES	NO
CELL PHONE/VOICEMAIL	YES	NO	YES	NO
OFFICE VOICEMAIL	YES	NO	YES	NO
MAIL	YES	NO	YES	NO
EMAIL	YES	NO	YES	NO
PRIVATE FACE WITH OTHERS(SEE BELOW)	YES	NO	YES	NO

OUR OFFICE WILL NOT BE RESPONSIBLE FOR ANY HIPAA VIOLATION IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS.

****

MAY WE DISCUSS YOUR APPOINTMENT OR MEDICAL INFORMATION WITH PEOPLE BESIDES YOURSELF? YES__________ NO____________

IF YES, PLEASE LIST THEIR CONTACT INFORMATION

NAME____________________________RELATIONSHIP_________________PHONE NUMBER__________

NAME____________________________RELATIONSHIP_________________PHONE NUMBER__________

NAME____________________________RELATIONSHIP_________________PHONE NUMBER__________

ADDITIONAL HIPAA INSTRUCTIONS WE SHOULD FOLLOW:

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BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND THE ABOVE HIPAA QUESTIONS. I ALSO ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY POLICY. INFINITY ORTHOPEDICS WILL ABIDE BY THIS POLICY.

SIGNATURE______________________________DATE_______________________________________