Hand, Microsurgery and Reconstructive Orthopaedics, LLP

John D. Lubahn, MD *MaryBeth Cermak, MD* *John M. Hood, MD*

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Patient Name: _____ Date of Birth: _____

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Hand, Microsurgery and Reconstructive Orthopaedics, LLP has the right to change its privacy practices from time to time and I may contact Hand, Microsurgery and Reconstructive Orthopaedics, LLP to obtain a current copy of the brochure.
I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the request restrictions.

Name: _____ Signature: _____ Date: _____

MEDICAL RELEASE (including minors)

I hereby authorize Hand, Microsurgery and Reconstructive Orthopaedics, LLP to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and /or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing. I also understand that by law HMRO may not be able to agree to the requested restrictions.

IF YOU WOULD LIKE SOMEONE OTHER THAN YOURSELF TO BE ABLE TO MAKE APPTS OR CALL IN REFILLS LIST THEM OR WRITE "NONE".

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Further, I hereby authorize and give my consent to Hand, Microsurgery and Reconstructive Orthopaedics, LLP to leave messages on my answering machine/voicemail system for the following:

_____Appointment reminders (including return telephone calls)
_____Test Results
_____**Do not leave message**

CONSENT TO PHOTOGRAPHY

The undersigned, having the right to permit the taking and use of photographic recordings of his/her physical condition or treatment, does hereby grant to Hand, Microsurgery and Reconstructive Orthopaedics, LLP, their agents, assigns, licensees and legal representatives the full right to use such photographs (and copyright same) for education purposes.

Signature _____ Date _____