



Notice of Privacy Practices Patient Acknowledgement

I have received the **Notice of Privacy Practices** written in plain language for the orthopedic practice of South Shore Orthopedics, LLC.

The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its **Notice of Privacy Practices** and to make changes regarding all protected health information resident at or controlled by this practice.

I understand information will be disclosed to others who assist in my care such as my spouse, children or parents and will allow information to be left on my answering machine.

I understand I can obtain a copy of this practice's current **Notice of Privacy Practices** on request.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____