



COASTAL ORTHOPEDICS & SPORTS MEDICINE

Patient Name: _____ SSN: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

- Coastal Orthopedics and Sports Medicine
- Coastal Foot & Ankle Center
- Coastal Pain Management

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that I have received the attached Privacy Notice.

**Patient or Personal Representative
Signature**

Date

Printed Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

.....

Please answer the following questions to help us protect your privacy:

- 1) May we leave a detailed message on your answering machine? YES / NO ph# _____
- 2) May we leave a message at your place of employment? YES / NO ph# _____

If the answers to the above questions are NO, please let us know how you wish to be notified by our office:

- 3) May we release information to anyone other than you? YES / NO (i.e. spouse, child, friend, etc.)

If the answer is YES, please list each person:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please list any doctors you currently see that the physician may need to speak with or obtain records from:

(WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE)