

# **Lakewood Orthopaedics & Sports Medicine**

## **Acknowledgement of Receipts**

### **Notice of Privacy Practices**

I have been provided with a Notice of Privacy that provides me a more complete description of the uses and disclosures of certain health information. I understand Lakewood Orthopaedics & Sports Medicine reserves the right to change their Notice of Privacy Practice and prior to implementation will provide an updated Notice of Privacy Practice and prior to implementation will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Lakewood Orthopaedics & Sports Medicine to share my protected health information with anyone listed below (Please include the name of your coach or athletic trainer):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

Authorization given to appropriate staff of the sports team  
for the purpose of continual medical care

\_\_\_\_\_  
Phone #