

Upper Bucks Orthopaedic Association

HIPAA Acknowledgement Form

I, _____, DOB: _____, understand that as part of my health care, UBO originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that UBO reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

Signature of Patient (or Patient's Legal Representative)

Date

Personal Representative Information (if applicable)

Name of Personal Representative

Relationship to Patient (or other authority)
