CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Brookwood Orthopedics, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent and to request a copy. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (205) 870-1498 and requesting a revised Notice. We will also post any revised notice in this office. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

We are required by law to use reasonable efforts to maintain the privacy of, and provide individuals with, the posted Notice of Privacy. It stipulates our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Brookwood office. By signing below, you acknowledge that you have received this notification and been informed of your privacy rights.

AGREED AND ACKNOWLEDGED:

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SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

____
PRINT NAME

Date__________________

OFFICE USE ONLY:

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