



*Orthopedics International, Ltd., P.S.*

**ACKNOWLEDGEMENT OF  
PRIVACY PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of *Orthopedics International, Ltd., P.S. Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information.

I have been given the right to review and receive a copy of such **Notice of Privacy Practices**.

I understand that *Orthopedics International, Ltd., P.S.* has the right to change the **Notice of Privacy Practices** and that I may contact this office at the address below to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and; I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

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**For official use only:**

We are unable to obtain the patients written acknowledgment of our **Notice of Privacy Practices** due to the following reasons:

- Patient refused to sign
- Emergency situation
- Communications barriers
- Other

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