DRS. ANDERSON, DELLAMAGGIORE, CHEN, ET AL.
Orthopedic Surgery

NOTICE OF PRIVACY PRACTICES CONSENT (HIPAA)

I hereby give consent/authorization to Drs. Anderson, DellaMaggiore, Chen, et al. to release either verbally or in-writing Protected Health Information (PHI) including all medical information with regard to my care and treatment to the following individuals:

1)_____
Name **Relationship**

2)_____
Name **Relationship**

3)_____
Name **Relationship**

4)_____
Name **Relationship**

☐ **INFORMATION IS NOT TO BE RELEASED TO ANYONE**

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Drs. Mark Anderson, Jeffrey Anderson, Eugene DellaMaggiore or Eli Chen.

Patient Signature_____ Date _____

Printed Name _____ DOB _____

Guardian Signature (if patient is a minor) _____

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