



HIPAA Acknowledgement

I authorize Advanced Orthopedic Center to discuss appointments & medical information with the following persons, not directly involved in my care: (please list all applicable parties)

Power of Attorney Yes (please bring paperwork) No

Emergency Contact *

First Name

Last Name

Phone *

Relationship

From the registration form

Additional Parties

I acknowledge the above information is accurate and correct to the best of my knowledge. I understand that the above listed individuals are authorized to receive information regarding my appointments and medical care.

Advanced Orthopedic Center complies with Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Advanced Orthopedic Center does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

I acknowledge the above information is accurate and correct to the best of my knowledge. I understand the the above listed individuals are authorized to receive information regarding my appointments and medical care.

Signature * Type your name in lieu of a signature.

Date: