Berkshire Orthopedic Associates, Inc.
A division of Keystone Orthopaedic Specialist, LLC.

PATIENT NAME:_____ DATE OF BIRTH:_____

Acknowledgment of Notice of Privacy Practices

Our **Notice of Privacy Practices** provides information about the ways in which we may use and disclose health information about your (for purposes of treatment, payment and health care operations) and describes your rights and our obligations regarding the use and disclosure of that information. Federal regulations require that we give our patients or their authorized representatives our Notice of Privacy Practices before signing this acknowledgment form. In addition, to the copy we may provide you in our office, our Notice of Privacy Practices is posted in our waiting room.

By signing this form, I am acknowledging that I have been offered and/or received a copy of Berkshire Orthopedic Associates, Inc. Notice of Privacy Practices.

_____ _____
Patient's signature (or authorized Personal Representative's signature & printed name) Date

For Office Use Only: A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices. The following explanation identifies the reason the acknowledgment was not obtained:

_____ _____ _____
Explanation Signature of Staff Member Date

Authorization of Verbal Release of Protected Health Information

According to federal privacy regulations, the release of your protected health information is permitted only for reasons as described in the Notice of Privacy Practices, or as otherwise allowed by the **specific signed authorization** of the patient or authorized personal representative.

I authorize the physician and staff of Berkshire Orthopedic Associates, Inc to discuss my health information with the following person (s).

Name/Relationship_____phone #_____

Name/Relationship_____phone #_____

Name/Relationship_____phone #_____

Or ◯ **I decline, do not discuss my care with anyone other than as allowed by federal regulations.**

*Please note that certain information cannot be released without specific authorization as required by state or federal law. This includes the following: information regarding the patient's diagnosis and treatment for HIV/AIDs, psychotherapy notes from a Psychiatrist o Psychotherapist and treatment for alcohol or drug abuse reports.

You may write us a letter cancelling your authorization at any time. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

By signing, I am authorizing the physician and staff of Berkshire Orthopedic Associates, Inc, to speak to the person (s) noted above on my behalf about my health information.

_____ _____
Patient's Signature (or Authorized Personal Representative's Signature and Printed Name) Date

This authorization will expire 3 years from the date of signing. This form is not valid unless signed and dated.

TURN OVER ⟶

This authorization permits BOA to use and/or disclose the following health information about me. Please read the selections carefully and check only the boxes that apply.

A ☐ BOA staff may leave messages on answering machine/voice mail with confidential message (i.e. apt reminders, normal test results, medications and other treatments).

This call may be placed to my cell phone ☐ home phone ☐ work phone ☐

B ☐ BOA may leave messages on an answering machine with another person as specified/named above about apts, normal tests results, medications and other treatments.

The following statement means that we will not share any information with any person other than you. YOU SHOULD NOT CHECK THIS IF YOU HAVE CHECKED IF YOU HAVE CHECKED SECTION B & LISTED NAMES ABOVE.

C ☐ I do not want any protected health information shared with others.