

# Watauga Orthopaedics, PLC

## Privacy Notice Acknowledgement

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

Account #: \_\_\_\_\_

I acknowledge that I have received a copy of the Privacy Notice for Watauga Orthopaedics.

If for some reason the facility needs to relay my protected medical information, i.e. test results or billing issues, etc., you can either leave or discuss the information with the following individual(s):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

I hereby authorize Watauga Orthopaedics to use or disclose the following protected health information:

- Work restrictions may be released to my employer.
- School excuses and/or restrictions may be released to the appropriate facility.
- If my primary care physician did not refer me to Watauga Orthopaedics, please send him/her a copy of my records.
- You may leave a message on my answering machine.

By signing below, I agree to the fore mentioned statements.

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Personal Representative's Relation to Patient

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### ABOVE – Patient or Personal Representative Use Only

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### BELOW – Provider Use Only

#### Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has made to obtain a written acknowledgment of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement.
- Patient was unable to sign because: \_\_\_\_\_
- There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- Other reason, described as: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date