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HIPPA PATIENT COMMUNICATION POLICY

Top Orthopedic Experts Dedicated to Summit County

Patient Name _____ Date of Birth _____

Under HIPAA, we may discuss your protected health information, including care or financial information with individuals involved in your care if you are not present or do not have the capacity to agree or object, if in the professional judgment of a Summit Orthopedics physician or other caregiver, we conclude that the disclosure is in your best interest. The disclosure is limited, in this circumstance, to protected health information that is directly relevant to that individual's involvement in your care. If you would like to identify specific individuals to whom we may make the foregoing disclosures, such as in the event Summit Orthopedics is unable to reach you or in response to an inquiry, please list them here:

1st) _____ 2nd) _____
Name phone Name phone

Communications: Please specify certain ways we may or may not communicate with you. This is to include appointment reminders, test results, prescription refills and financial communications.

- Phone Number: Yes No Leave messages on my answering machine/voice mail
 Yes No Leave messages with any other person answering the phone
 Yes No Utilize text messaging for appointment reminders Cell _____**
 Yes No Attempt to contact me via the my email address

By providing your cell number and email you are agreeing to be contacted for appointment reminders and physician surveys. We utilize third party companies such as ZocDocs, Televoxx and Press Ganey to provide healthcare operation services.

I understand the contact information on the Registration Form will be relied upon to communicate with me regarding my medical and financial information until such time as I notify POSC in writing of a change, at the address listed below.

HIPAA Acknowledgement: I acknowledge I have been provided with Summit Orthopedics' Notice of Privacy Practices or with an opportunity to obtain a copy and I have declined. PLEASE SEE THE Summit Orthopedics' NOTICE OF PRIVACY PRACTICES FOR A COMPLETE STATEMENT OF OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AND YOUR ASSOCIATED RIGHTS. OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE, WWW.SUMMITORTHOPANORAMA.COM OR AT ANY OF OUR OFFICES.

Electronic Medical Records and Prescription Access: I acknowledge that the office uses electronic medical records and may use such system to look at and prescribe medications.

Printed Name Date Signature of Patient/Guardian

Reason Patient Unable to Sign/Guardian Relationship

For further questions, or to change/revoke your information, please contact our Privacy Officer, Steve Nelson at: 303-233-1223.