SOUTHSIDE ORTHOPAEDICS P.C.

Notice of Privacy Practices

Patient name:_____**Date of Birth:**_____

I have received the Notice of Privacy Practices from Southside Orthopaedics, P.C.. ◯ **yes** ◯ **no**

My medical care may be discussed with my: ◯**spouse** ◯ **significant other** ◯ **parent**◯ **child**

List all names that apply:_____

_____

Test results may be left on my answering machine/voicemail/email: ◯**yes** ◯**no**

Appointment information may be left on my answering machine/voicemail/email: ◯ **yes** ◯**no**

Patient Signature:_____**Date:**_____

For personal representative of the patient *(if the patient is a minor or the patient is unable to make their own medical decisions.)*

Print name of personal representative:_____

Describe personal representative relationship:_____

Signature of personal representative:_____