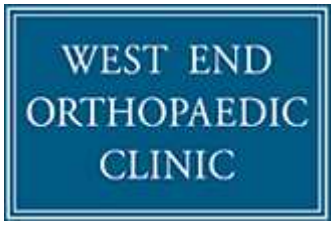

Notice of Privacy Practices
Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change in accordance with Federal regulations. A current copy may be obtained by requesting a copy or by viewing the notice on our website at: http://www.weoc.com.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement. Any request to restrict our use of your information must be done in writing to our practice Privacy Officer at 500B Hioaks Road, Richmond, Virginia 23225.

West End Orthopaedic Clinic intends to use and disclose the minimum necessary PHI about you for treatment, payment, or health care operations. Other uses and disclosures not described as permitted in our Notice of Privacy Practices will require a current signed and dated authorization from you or your legal appointed representative.

I, _____ (***Please print patient name***) have been provided a copy of the Notice of Privacy Practices for West End Orthopaedic Clinic.

I understand that I may ask questions to West End Orthopaedic Clinic staff if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient Signature Date

If patient is a minor or is unable to sign:

_____ _____

Authorized Representative Date Relationship to Patient