

ROME ORTHOPAEDIC CLINIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I read, as of the date below, the "Notice of Privacy Practices" of Rome Orthopaedic Clinic. This document contains a description of the uses and disclosures of my healthcare information, and my rights regarding such information. I have been given the right to review this notice prior to signing the consent.

I understand that this organization has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the office of Rome Orthopaedic Clinic.

I also understand that if I have any questions, or wish to receive additional copies or a current copy of this "Notice of Privacy Practices", I may contact:

Privacy Officer
Rome Orthopaedic Clinic
100 Three Rivers Dr NE
Rome GA 30161
Phone: (706) 292-0040
Fax: (706) 378-0556

Patient Name (Printed): _____

Signature: _____

Relationship to Patient: _____

Date: _____

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Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date:	Initials:	Reason:
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