Dubuque Orthopaedic Surgeons, PC
1500 Delhi Street, Suite 4200
Dubuque, IA 52001

ACKNOWLEDGEMENT RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Dubuque Orthopaedic Surgeons, PC. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Notice of Privacy Practices also describe my rights and the responsibilities and duties of Dubuque Orthopaedic Surgeons, PC with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Dubuque Orthopaedic Surgeons, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY
In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below including my listed emergency contact.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐YES	☐NO
SPOUSE/PARTNER ONLY	☐YES	☐NO
OTHER (PLEASE SPECIFY) _____	☐YES	☐NO

MY SIGNATURE BELOW ACKNOWLEDGES I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS ACKNOWLEDGEMENT AND/OR CHANGES IN THE ADDITIONAL DICLOSURE AUTHORITY AT ANY TIME.

_____ _____
PATIENT NAME (PRINTED) DATE

(PRINT, SIGN AND RETURN TO OFFICE **OR** CLICK THE BOX TO CREATE AND ADD A DIGITAL SIGNATURE)

_____ _____
SIGNATURE OF PATIENT/LEGAL RESPRESENTATIVE GUARANTOR NAME (PRINTED)

RELATIONSHIP TO PATIENT