ORTHOPEDIC
CENTER OF ILLINOIS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how the practice may use and disclose my confidential information. **I am only acknowledging receipt of the policy.**

Please specify your relationship to the patient: _____

_____ _____
Signature of patient or representative Date

INFORMATION AUTHORIZATION

For the Orthopedic Center of Illinois, Ltd. To disclose private health information about you to parties covered in our Notice of Privacy Practices, you will need to complete this section.

☐ Yes, you may provide information to the parties listed below:

_____

☐ No, I do not wish the Orthopedic Center of Illinois, Ltd. to discuss my information with any party other than myself.

_____ _____
Signature of patient or representative Date

Appointment Reminders via Text

☐ Yes I would like to have my appointment reminders sent via text to my cellular phone and realize all message and data rates may apply. Texts will be received from OrthoCenterILL. My cell phone contact is: _____