ORTHOPEDIC
CENTER OF ILLINOIS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, 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.

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.

Name of Patient: _____

Relationship to Patient: ☐ Self ☐ POA ☐ Parent/Guardian

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

☐ **Yes, you may provide information to the parties (including Emergency Contacts) listed below:**

Name	**Phone Number**	**Relationship**

X_____ _____
Signature of patient or representative **Date**

Orthopedic Center of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Revised: 09/2023