



HIPAA Notice of Privacy Practices

Patient: _____

Email Usage:

I give my permission for Davis Orthopedics to communicate with me via email regarding my medical, account, and appointment information. Your email address will not be shared with anyone else.

_____ ***PRINT CLEARLY.**

Email address.

Release of Information

- I want Davis Orthopedics to communicate **only with me** regarding my medical, account, and appointment information.
- I give my permission to Davis Orthopedics to release my medical, account, and appointment information to **my family members or individuals** involved in my care.
- I give my permission to Davis Orthopedics to release my medical, account, and appointment information to the following **specific people that are not family members**.

Restrictions:

- Davis Orthopedics is **restricted** from releasing my medical, account, and appointment information to the following specific person(s).

I have been provided a copy of Davis Orthopedics' HIPAA Notice of Privacy Practices and have been notified of the above information.

Signature of Patient/Account Guarantor

Date