

ORTHOPAEDIC CARE SPECIALISTS

733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408
PHONE (561) 840-1090 FAX (561) 840-0791

CONSENT TO DISCUSS OR RELEASE INFORMATION

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ hereby
give consent to *Orthopaedic Care Specialists* to discuss or release my private health care information to:

who is related to me

is my care giver, unrelated to me

I fully understand and accept the terms of this consent. I have been informed of my rights according to HIPPA Regulations. I have reviewed and have had the opportunity to receive a copy of *The Notice of Privacy Practices at Orthopaedic Care Specialists*.

Signature _____

Date _____