Orthopaedic Associates of Riverside

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Orthopaedic Associates of Riverside (OAR)
(Name of Patient or Authorized Agent)
to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the main office located at 353 E. Burlington Street, Suite 100, Riverside, Illinois 60546.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____Date: _____

If you are not the patient, please specify your relationship to the patient _____.

Authorization to Release Information

The HIPAA Privacy Act of April 2003 prohibits us from speaking to anyone other than yourself, your legal guardian or your power of attorney in regards to not only your medical condition but your medical bills as well. We have found that this causes some frustration for family members when trying to assist their loved ones with medical decisions and financial situations. To that end we would like to minimize these frustrations by asking that you give prior approval for anyone you may want to grant us authorization to speak with. **Please understand that it is your right to refuse to authorize us to speak with anyone, however if not expressly granted permission to do so, our staff will not be able to speak with anyone other than yourself, your legal guardian or your power of attorney. Please note that workers compensation claims are not subject to the HIPAA Privacy Act and that medical records and financial information will be released to your employer, worker's compensation carrier and/or their employees for purposes of obtaining payment.**

I hereby authorize representatives of Orthopaedic Associates of Riverside to speak with (please print):

Name of Individual	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

May we leave messages on your answering machine/voicemail? YES_____ NO_____

_____ _____
Signature Date