



HIPAA Notice of Privacy Practices

Effective 03/16/2023

Patient: _____

Text and Email Usage:

_____ *PRINT CLEARLY.

Cell phone number

_____ *PRINT CLEARLY.

Email address.

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

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