Name:
DOB:
Chart:
Age:
Date:

HIPAA AGREEMENT

By signing below, I acknowledge that Notice of Privacy Practices is available in the lobby, on the website or I may request a copy.

____
Signature (Patient or Authorized Representative)

Date: **AppDate**

____
Printed (Patient or Authorized Representative)

This authorization shall expire 1 year from the date of signature.

HIPAA AUTHORIZATION FORM

Bayside Orthopaedic Sports Medicine & Rehab Center has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf.

I, ______________________________, am authorizing the person/people listed below to obtain medical information about myself. I understand that Bayside Orthopaedic Sports Medicine & Rehab Center is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person

1. Name: ______________________________ Date of Birth: ____________________

2. Name: ______________________________ Date of Birth: ____________________

3. Name: ______________________________ Date of Birth: ____________________

Patient's Signature: ______________________________ Date: ____________________

Declination of Release of Medical Information

I, ______________________________, **do not authorize** Bayside Orthopaedic Sports Medicine & Rehab Center to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature: ______________________________ Date: ____________________

Consent to Use & Disclosure of Protected Health Information (HIPAA)