ATLANTIS ORTHOPAEDICS
CONSENT

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY ATLANTIS ORTHOPAEDICS FOR THE PURPOSE OF DIAGNOSING OR PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTHCARE BILLS OR TO CONDUCT HEALTHCARE OPERATIONS OF ATLANTIS ORTHOPAEDICS.

I UNDERSTAND THAT THE DIAGNOSIS OR TREATMENT OF ME BY DR. JEFFREY S. PENNER, DR. SCOTT D. NORRIS, DR. HOWARD D. ROUTMAN, DR. ROMMEL R. FRANCISCO, AND DR. JOHN WANG MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT.

I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO H0W MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS OF THE PRACTICE. ATLANTIS ORTHOPAEDICS IS NOT REQUIRED TO AGREE TO RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF ATLANTIS ORTHOPAEDICS AGREES TO A REQUEST THAT I REQUEST, THE RESTRICTION IS BINDING ON ATLANTIS ORTHOPAEDICS AND DR. JEFFREY S. PENNER, DR. SCOTT D. NORRIS, DR. HOWARD D. ROUTMAN, DR. ROMMEL R. FRANCISCO, AND DR. JOHN WANG.

I HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT DR. JEFFREY S. PENNER, DR. SCOTT D. NORRIS, DR. HOWARD D. ROUTMAN, DR. ROMMEL R. FRANCISCO, AND DR. JOHN WANG OR ATLANTIS ORTHOPAEDICS HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTHCARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR A HEALTHCARE CLEARING HOUSE. THIS PROTECTED HEALTH INFORMATIONM RELATES TO MY PAST, PRESENT OR FUTURE PHYSCIAL AND MENTAL HEALTH OR CONDITION AND IDENTIFIES ME OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

TURN PAGE OVER AND SIGN ⇒

I UNDERSTAND I HAVE A RIGHT TO REVIEW ATLANTIS ORTHOPAEDICS NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. ATLANTIS ORTHOPAEDICS NOTICE OF PRIVACY PRACTICES HAS BEEN PROVIDED TO ME. THE NOTICE OR PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS OR IN THE PERFORMANCE OF HEATHCARE OPERATIONS OF ATLANTIS ORTHOPAEDICS. THE NOTICE OF PRIVACY PRACTICES FOR ATLANTIS ORTHOPAEDICS IS ALSO PROVIDED IN THE WAITING ROOM OF THE OFFICE. THIS NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND ATLANTIS ORTHOPAEDICS'S DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

ATLANTIS ORTHOPAEDICS RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES BY CALLING THE OFFICE AND REQUESTING A REVISED COPY BE SENT IN THE MAIL, OR ASKING FOR ONE AT THE TIME OF MY NEXT APPOINTMENT.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority