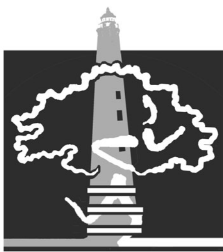

SHAWS COVE ORTHOPÆDICS

Jeffrey A. Miller, D.O.
Board Certified Orthopaedic Surgeon
Peter A. Wheeler, PA-C
Physician Assistant

Use and Disclosure of Personal Health Information Agreement

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Shaws Cove Orthopaedics will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge and agree that Shaws Cove Orthopaedics may use or disclose my medical information for the purpose of my treatment, or for obtaining payment for services rendered. I am aware that Shaws Cove Orthopaedics may disclose my medical information to a Business Associate for the same reasons, and that the Business Associates will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosures, under HIPAA.

Acknowledged and agreed to by:

Patient:________________________________ or

Representative:________________________________

Signature:____ Date:______/______/______

Finally: The Federal Government now restricts this office and Dr. Miller, Mr. Wheeler PA, from discussing your health information and condition with other family members or persons... unless you specifically give your written permission.

By my signature below, I grant Shaws Cove Orthopaedics permission to discuss my protected medical information with the following individuals.

______Release referrals/medical records to spouse/significant other________________________________

______Leave test results/appointment times on answering machine or leave it with your spouse/family member.

______Release medical records/information to other Physicians providing medical care.

____________________________________ ____________________________________

____________________________________ ____________________________________

Signature of Patient:____