Acknowledgement of Privacy Practices and Sharing Protected Healthcare Information

My signature below acknowledges that I have been offered the written Notice of Privacy Practices from Orthopaedic Associates of Green Bay, S.C. I further authorize Orthopaedic Associates of Green Bay to share my protected healthcare information with the named individuals listed below who are involved in my care:

Name of Authorized Individuals	Relationship to Patient
Name of Authorized Individuals	Relationship to Patient
Name of Authorized Individuals	Relationship to Patient

Patient Signature ____________________ **Date** ____________

Personal Representative,(describe relationship) ____________________ Date ____________

This authorization will remain in effect for one year from the date above

For Office Use Only

☐ The patient's condition prohibits the individual from signing acknowledgement at this time. The signature will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgement was unable to be obtained.

Reason: ________________________________

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Employee Signature ____________________ Date ____________