MILLSAP VALLEY
ORTHOPAEDICS
& SPORTS MEDICINE

Acknowledgement of Receipt of HIPAA Privacy Statement as Required by Law

Millsap Valley Orthopaedics & Sports Medicine has provided me with a written explanation of how medical information about me may be used and disclosed and how I can access this information. I acknowledge that I have received and read the information provided.

_____ _____

Patient Printed Name

Patient Signature
(Parent if minor)

_____ Date: ____/____ / ____

Office Representative

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices for Donal B. Rose, MD.
I authorize this office to release my confidential health information to the following friends and/or family members: (Please list name and phone #)

_____

_____

_____

_____

Patient Signature: _____ Date: _____