



HIPAA DISCLOSURE FORM

Because of the HIPAA privacy law, we are unable to release information about your care or discuss your treatment with anyone who may inquire on your behalf.

Please list below any individuals you give us permission to speak freely with about your medical care and treatment. This includes family members, spouses, significant others and friends. Medical information cannot be release or discussed without your prior consent.

You may at any time update or change this list.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

The providers of Chico Orthopaedic Surgery & Sports Medical Associates may call your home or other designated location and leave a message or voice-mail in reference to any items that assist them in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance and billing items and laboratory results, amongst others, relating to your care.

(Please Initial) _____ **Yes** _____ **No**

In addition, by signing below you acknowledge receipt of the HIPAA privacy policies as provided by our office.

Print Name: _____ DOB: _____

Signature: _____ Date: _____