

# Acknowledgement of Receipt of Notice of Privacy Practices

OrthoMed Center  
1335 Coffee Rd. Suite 100 • Modesto, CA 95355

**Collette Castillo, Privacy Officer 209-524-5977**

I hereby acknowledge that I received a copy of this medical practices's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

parent or guardian of minor patient

guardian or conservator of an incompetent patient

beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

In compliance with HIPPA regulations, I hereby authorize OrthoMed Center to disclose and discuss my medical care to \_\_\_\_\_  
Relationship \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

For Office Use Only:

Date received:	Processed by:
Practice Follow-up:      Yes      No	Date of Practice Follow-up: