

**ORTHOPEDIC INSTITUTE OF CENTRAL FLORIDA**  
**Notice of Privacy Practices Acknowledgment Form**

The Orthopedic Institute of Central Florida's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician's office or by visiting our Web site at [www.orthocf.com](http://www.orthocf.com).

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I have read the Orthopedic Institute of Central Florida's Notice of Privacy Practices**

\_\_\_\_\_  
Signature of Patient or Authorized Representative

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient Date of Birth

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ORTHOPEDIC INSTITUTE OF CENTRAL FLORIDA USE ONLY

Patient declined signing this acknowledgement form

Reason given: \_\_\_\_\_

Staff Member Name: \_\_\_\_\_

Office Location: \_\_\_\_\_ Date: \_\_\_\_\_