Acknowledgement of Receipt of Notice of Privacy Practices

Orthopedic Medical Group of Tampa Bay, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Orthopedic Medical Group of Tampa Bay, Inc.**

____
Name of Patient (Print or Type)

____ ________________
Signature of Patient Date

____
Signature of Patient Representative
(required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Representative to Patient

Person(s) authorized to discuss and/or receive medical and/or billing information on your (patient) behalf.

1. ____ ____________________
   Name and Relationship to Patient Phone Number

2. ____ ____________________
   Name and Relationship to Patient Phone Number