

Name: _____

Chart#: _____

1. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES:** I have received a copy of the Midlands Orthopaedics, P.A. (MOPA) Notice of Privacy Policies detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law. I understand that MOPA is permitted to disclose my PHI without my authorization to facilitate treatment, payment and health care operations. As permitted by HIPAA, I request the following restriction(s) to the release of my PHI for those specific purposes: _____

I understand that I will be notified by MOPA if my restriction request is denied. If the lines above are blank, I have not requested a restriction to the disclosure of my PHI for purposes of treatment, payment or health care operations.

2. **ASSIGNMENT OF BENEFITS:** I assign to Midlands Orthopaedics, PA (MOPA), any insurance or other third party benefits available for health care services provided to me. I understand that MOPA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to MOPA, I agree to immediately forward to the practice upon receipt all health insurance and other third-party payments that I receive for services rendered to me by MOPA.
3. **MEDICATIONS AND REFILL REQUESTS:** I understand that the providers of Midlands Orthopaedics, PA (MOPA) will not address requests for medications or refills of currently prescribed medications after regular business hours or on weekends. Requests for refills and/or changes to medications must be made during the normal business day. We apologize for the inconvenience, but "on-call" or "after-hours" staff members do not have access to the medical records needed to make decisions regarding medication changes or additions.

I _____ acknowledge receipt and understanding of the items described on this Authorization and Acknowledgement form.

Patient/Guardian Signature

Date