Patient Privacy Notice

Advanced Orthopaedic Associates, PA
9828 E. Shannon Woods Cir. #100
Wichita, KS 67226 316-631-1600
www.aoaortho.com
Billing Dept: 316-631-1699

Patient Name: _____
Date of Birth: _____
MR#: _____Account#:_____
Appt. Date: _____

Authorization for Care- I grant permission for AOA to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that care may include medical and surgical treatment, and diagnostic tests.

Authorization for Release of Information- I hereby authorize AOA to disclose necessary information from the patient's medical records to the **parties listed below** when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third-party payor for the purpose of obtaining payment to AOA for the services provided. AOA, its employees, and agents are released from legal responsibility or liability for the release of above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV, and the diseases, all of which I specifically authorize to be released.

Parties that are authorized to receive medical information other than the patient & patient's doctor(s).

_____ / Relation to patient_____
(please print)
_____ / Relation to patient_____
(please print)
_____ / Relation to patient_____
(please print)

Patient Privacy Act:

I acknowledge that the Notice of Privacy Practices of Advanced Orthopaedic Associates has been offered to me and I understand that it is available upon request at any time.

WITH THIS SIGNATURE BELOW I ACKNOWLEDGE ALL THE INFORMATION ABOVE.

x_____ _____ ____
Signature of Patient or Representative Relationship Date

Subject to change without notice.