Patient Privacy Notice

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

Patient Name: _____

Date of Birth: _____

MRN: _____

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.

Use of Artificial Intelligence (AI)-Powered Medical Documentation Tools: AOA may use AI-powered medical documentation tools to assist in the processing and documentation of health information during consultation and treatment. These tools are intended to improve the efficiency and accuracy of medical record documentation. There are potential risks associated with their use, including inadvertent errors in transcription or interpretation of health information. AOA mitigates these potential risks by requiring healthcare providers to review and sign medical record documentation generated with the assistance of AI.

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.