Rocco Prosthetic & Orthotic Center, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA), Supplier Standards and Patient's Rights Notice

I certify that I have been offered a copy of Rocco Prosthetic and Orthotic Center's **Notice of Privacy Practices, Supplier Standards and Patient Rights Statement**. The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rocco Prosthetic and Orthotic Center health care operations.

The **Notice of Privacy Practices** also describes my rights and Rocco Prosthetic and Orthotic Center duties with respect to my protected health information. The **Notice of Privacy Practices** is posted and available in Rocco Prosthetic and Orthotic Center's patient waiting area. The **Patient Rights Statement** informs RPOC's patients of their rights and responsibilities as a patient/client of our company. Medicare's **Supplier Standards** are a set of rules that RPOC, as a supplier, must abide by in my treatment of my health care needs. These rules are posted in our patient waiting area and are available upon request.

Rocco Prosthetic and Orthotic Center reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices** and the **Patient Rights Statement**. I may obtain a revised **Notice of Privacy Practices** and/or **Patient Rights Statement** by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Rocco Prosthetic and Orthotic Center to share my Protected Health Information (PHI) with the following persons:

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

X_____ **X** _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative Description of Representative's Authority

Office Use Only:

☐ Refused to sign document, information given to the patient

☐ Patient unable to sign document because: _____, information given to patient.

_____ _____

Signed by RPOC Representative Date

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