ORTHOPAEDIC SOLUTIONS AND SPORTS MEDICINE CENTER PA
JAY R PARIKH, FAAOS, FACS

Consent to Use or Disclose Information for Treatment, Payment, Health Care Operation Or other Uses Permitted Under HIPPA

The patient hereby consents to the use or disclosure of his/her individually identifiable Health Information ("protected health information") by Orthopaedic Solutions and Sports Medicine Center, PA. In order to carry out treatment, payment, or health care operations. The Patients should review our Notice of Information Practices for Protected Health Information for a more complete description of the potential use and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

Orthopaedic Solutions and Sports Medicine Center, PA reserves the right to change the terms of its Notice of Information Practices for Protected Health Information at any time. If we do change the terms of the Notice of Information Practices, a copy of the revised Notice will be mailed to you.

Patients retains the right to request that Orthopaedic & Sports Medicine Center further restrict how his/her protected health information is used to disclose carry out treatment, payment, or health care operations. Orthopaedic Solutions and Sports Medicine Center, PA is not required to agree to such requested restrictions: however, if we do not agree to the Patient's requested restrictions, such restrictions are then binding on Orthopaedic Solutions and Sports Medicine Center, PA.

At all times, the patient retains the right to revoke this consent. Such revocation must be submitted to Orthopaedic Solutions and Sports Medicine Center, PA in writing. The revocation shall be effective except to the extent that Orthopaedic Solutions and Sports Medicine Center, PA has already taken action in reliance on the consent.

Orthopaedic Solutions and Sports Medicine Center, PA may refuse treatment to the patient is he/she(or an authorized representative) does not sign this consent form (except to the extent that the our facility is required by law to treat individuals). If patient (or authorized representative) signs this Consent Form and then revokes Consent, Orthopaedic Solutions and Sports Medicine Center, PA has the right to refuse to provide further treatment to the patient as of the time of revocation (except to the extent that our facility is required by law to treat the individual).

I am authorizing that Orthopaedic Solutions and Sports Medicine Center, PA can leave general call back information regarding my medical treatment, payments or health care on my answering machine, cell phone, or with a family member that is authorized to answer my home phone and/or a general call back message with my employer.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ **Signature:**_____

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Printed Name/Responsible Party