

As part of our efforts to comply with HIPAA Privacy Regulations, we ask that you please provide the name of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account, or who have permission to pick up information **you** have requested

Name: _____ Relationship: _____

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I have been given a copy of the Cape Fear Orthopaedic Notice of Privacy Practice, version effective 2/1/2010. I consent to the uses and disclosures of my health information as outlined in the Notice.

X _____ Date _____
Signature of Patient or Representative

- Representative is the:
- Parent or legal guardian of the patient, who is a minor
 - Guardian of the patient, who has been adjudicated incompetent.
 - Representative acting under a Durable Power of Attorney for Health Care or Advance Directive for the patient, and has presented a copy of this document to Cape Fear Orthopaedic personnel.