GOLDEN ORTHOPAEDIC KNEE, HIP, SHOULDER AND FOOT CENTER

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Persons to whom my health information may be disclosed:

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RECEIPT OF NOTICE OF PRIVACY PRACTICE

My signature on this form acknowledges that I have received a copy of Golden Orthopaedic Knee, Hip, Shoulder and Foot Center, Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Golden Orthopaedic Knee, Hip, Shoulder, and Foot Center, Inc., my rights with respect to my health information, and the responsibilities of Golden Orthopaedic Knee, Hip, Shoulder, and Foot Center, Inc., related to protecting my health information.

Name	Relationship	Telephone	-
Name	Relationship	Telephone	-
I certify that I have read and fully und	derstand the above information.		
Patient Name (please print)		Date	
Patient's Signature			