HIPAA Form
For the Use and Disclosure of Health Information

Orthopaedics Northeast, P.C.
575 Turnpike Street Suite 11
North Andover, MA 01845

Name of Patient:____

Social Security Number:____

Date of Birth:____

By signing this HIPAA Form, I acknowledge that I have received the Notice of Privacy Practices and:

1. I am aware that Orthopaedics Northeast, P.C. must use and disclose my identifiable health information for the following purposes and activities:

> **Treatment** (Including, but not limited to, disclosures necessary for consultations with and/or referrals to other providers, the coordination of the provision of care, and the scheduling of care. Including disclosures to the Radiology Scheduling Line.)
>
> **Payment** (Including, but not limited to, disclosures necessary for obtaining reimbursement for the provision of care, determining eligibility for coverage, billing and utilization review.)
>
> **Health Care Operations** (Including, but not limited to, disclosures necessary for conducting quality assessment and improvement programs, care coordination, evaluating provider performance, conducting provider training programs, and business management and administrative activities of Orthopaedics Northeast, P.C.)

2. The information disclosed may include information relating to the patient's:

> Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS")
> Treatment for or history of drug or alcohol abuse
> Mental or behavioral health or psychiatric care
>
> Unless specific request is received in writing

Signature of patient or patient's representative:____

Date:____

Printed name of patient's representative:____

Relationship to patient giving representative authority to act for patient:______________________