



## Notice of Information Practices

The Orthopaedic Center of Central Virginia, Inc. is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with the Notice of our legal duties and privacy practices with respect to protected health information. The Orthopaedic Center of Central Virginia, Inc. is required by law to abide by the terms of this Notice.

1. The Orthopaedic Center of Central Virginia, Inc. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. The Orthopaedic Center of Central Virginia, Inc. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. The Orthopaedic Center of Central Virginia, Inc. will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. The Orthopaedic Center of Central Virginia, Inc. will abide by the terms of this notice currently in effect at the time of the disclosure.
5. The Orthopaedic Center of Central Virginia, Inc. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. The Orthopaedic Center of Central Virginia, Inc. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any patient, guardian or personal representative has the right to request to inspect and obtain copies of their medical record.
8. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
9. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.
10. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.
12. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number The Orthopaedic Center of Central Virginia, Inc., 2019 Tate Springs Road, Lynchburg, Virginia 24501, Telephone 434-845-7035 and Fax Number 434-845-6940. All complaints will be addressed and the results will be reported to the Privacy Officer.
13. It is the policy of The Orthopaedic Center of Central Virginia, Inc. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

**Print Patient's Name:** \_\_\_\_\_

**Signature of Patient or Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**CONSENT FORM**  
**(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)**

I understand that as part of my healthcare, The Orthopaedic Center of Central Virginia, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

With this consent, The Orthopaedic Center of Central Virginia, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, The Orthopaedic Center of Central Virginia, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, The Orthopaedic Center of Central Virginia, Inc. may e-mail to me appointment reminders and patient statements. I have the right to request that The Orthopaedic Center of Central Virginia, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Orthopaedic Center of Central Virginia, Inc. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, The Orthopaedic Center of Central Virginia, Inc. may decline to provide treatment to me.**

**Print Patient Name:** \_\_\_\_\_

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**PERMISSION TO AUTHORIZE TREATMENT**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the above named patient:**

**NAME**

**RELATIONSHIP**

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**Signature of Patient, Parent or Guardian**

\_\_\_\_\_  
**Date**

**In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.**

**Patient Identifier:** \_\_\_\_\_

[Last four (4) digits of your Social Security Number]