



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have received or have been offered West Idaho Orthopedics and Sports Medicine's Notice of Privacy Practices. I understand that the Notice of Privacy Practices contains important information about my rights and obligations concerning my health information. I also understand that I may direct any questions or concerns about the Notice of Privacy Practices to the Privacy Contact person noted in Section 1.

Date

Signature of Patient or Personal Representative If Patient is Unable to Sign.

Patient's Name

Personal Representative's Name if Signing for Patient

Relationship to Patient

Additional Authorized Names Who May Inquire About Protected Health Information

_____	_____
_____	_____
_____	_____

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