PHILADELPHIA ORTHOPAEDIC ASSOCIATES
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ORTHOPAEDIC SURGERY
ANDREW J. COLLIER, JR., M.D.
JOHN P. SALVO, M.D.
MARC S. ZIMMERMAN, M.D.

PATIENT NAME: _____
(Please print)

DATE OF BIRTH:_____

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND AUTHORIZATION TO RELEASE HEALTH INFORMATION.

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Dr. Andrew J. Collier, Jr., Dr. John P. Salvo, and Dr. Marc S. Zimmerman. In addition, by signing below, I authorize Dr. Andrew J. Collier, Jr., Dr. John P. Salvo, and Dr. Marc S. Zimmerman to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

SIGNATURE:_____

TODAY'S DATE:_____

INABILITY TO OBTAIN ACKNOWLEGEMENT:
To be completed if not signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____ Individual refused to sign.

_____ An emergency situation prevented us from obtaining the acknowledgement.

Privacy Representative,
Donna Messner