Acknowledgment of Receipt of Notice of Privacy Practices

Trinity Orthopedics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Trinity Orthopedics**

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____

Relationship of Patient Representative to Patient