

Patient name: (first)_____ (middle initial)_____ (last)_____

HEALTHCARE RECORDS RELEASE / PRIVACY PRACTICES FOR THE CLINIC OF SUE ROMANICK MD PLLC

It's about your right to privacy. Allowing the release of healthcare information about you, including initial consultation notes, follow-up progress notes or test results, will allow us to build a strong healthcare team around you. The healthcare provider who has recommended that you see us will be sent information automatically unless you inform us of your wishes otherwise. Please list any referring healthcare providers below. Please be sure to include any orthopedic surgeon whom you have seen and any other healthcare providers whom you feel should receive records from this clinic. You may also want information conveyed to claims managers, counselors, lawyers and other healthcare providers. To prevent delays in information transmission, please provide complete contact information below and indicate where records are to be sent:

Name Fax Address	Clinic/company Phone
Name Fax Address	Clinic/company Phone
Name Fax Address	Clinic/company Phone
Name Fax Address	Clinic/company Phone

Our privacy practices are posted in the clinic. However, if we need to contact you urgently regarding test results we need your permission to leave this information for you if you are not immediately available. Please INITIAL in front of as many options you will agree to below and provide additional information as necessary:

- home answering machine _____
- cell phone _____
- with spouse or partner (specify name) _____
- home fax machine _____
- answering machine at work _____
- other (specify) _____

PLEASE READ AND SIGN: I acknowledge receipt of or have read the Notice of Privacy Practices for the clinic of Sue Romanick MD PLLC.

Your signature: _____ Date: _____