



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND  
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **Orthopaedic & Spine Specialists, PC, (OSS)** to use and disclose health information about your for treatment, payment, and health care operations purposes.

**Notice of Privacy Practices.** OSS has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

**Amendments.** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

**How to contact our Privacy Officer:**

Mail: Orthopaedic & Spine Specialists, P.C.  
1855 Powder Mill Road  
York, PA 17402  
Attention: Privacy Officer  
Telephone: (717) 848-4800  
Facsimile: (717) 848-4597

**Acknowledgment and Consent**

Print or type all information except the signature.

I have received the Notice of Privacy Practices for **OSS**. **OSS** is authorized to use and disclose health information about:

\_\_\_\_\_ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient  
(or patient’s personal representative)

\_\_\_\_\_  
Date

Personal representative information (if applicable):

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient (or other authority)