

**BEACON ORTHOPAEDICS & SPORTS MEDICINE
BEACON ORTHOPAEDICS SURGERY CENTER, LLC
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name : _____

Patient Signature: _____ Date: _____

Designation of a Personal Representative

A patient **may** designate a personal representative in writing. A personal representative may be a spouse, adult child, or other members of the patient's family. A personal representative also may be a close personal friend or any individual with power of attorney or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. A parent or legal guardian of a minor (generally a child under the age of 18) will be recognized as a personal representative of the child.

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient. Such information could include: appointment changes, messages regarding surgery and/or testing, physician's responses to phone messages and medication requests. **PLEASE NOTE: an answering machine cannot be used as an acceptable way of leaving information.** A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.

Persons to whom my information may be disclosed:

Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Patient Signature: _____ Date: _____

You may revoke or terminate this authorization at any time by submitting a written revocation to Beacon Orthopaedics and Sports Medicine/Beacon Orthopaedics Surgery Center, LLC.

45 CFR 164.502 (g) (1)
45 CFR 164.502 (g) (2) (3) and (4)