Sonoran HIP CENTER

Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

PRIVACY PRACTICES AND INSTRUCTIONS FOR
DISCUSSING PERSONAL HEALTH INFORMATION

Patient Name: _____ Date of Birth _____

Phone number: _____Today's Date: _____

Notice of Privacy Practice and Patient Rights

☐ I acknowledge receipt of the Sonoran Hip Center Notice of Privacy Practices and Patient Rights

Instructions for Discussing my Personal Health Information with Others

I give permission to Sonoran Hip Center to discuss my personal health information with the following individuals:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

I give permission to Sonoran Hip Center to communicate massages regarding appointments, referrals, lab results, and x-ray results as follows:

☐ You may leave a message on my answering machine

☐ You may leave a message with

_____

☐ Other (please specify)

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative Relationship to Patient