

## **Consent to Use and Disclosure of Protected Health Information**

### **Use and Disclosure of Your Protected Health Information**

Your Protected health information will be used by **AO Orthopedics, Inc.** or disclosed to others for the purposes of treatment, obtaining payment, or supporting day to day health care operations

### **Notice of Privacy Practices**

Prior to signing this consent review the Notice of Privacy Practices provided at the front desk for a more complete description of how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

### **Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information.

**AO Orthopedics, Inc.** may or may not agree to restrict the use or disclosure of your protected health information.

If **AO Orthopedics, Inc.** agrees to your request, the restriction will be binding on the practice. Use or disclosure of the protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information at any time. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Right to Change Privacy Practices**

**AO Orthopedics, Inc.** reserves the right to modify the privacy practices outlined in the notice.

### **Signature**

I have reviewed this consent form and the Notice of Privacy Practices and give my permission to **AO Orthopedics, Inc.** to use and disclose my health information in accordance with it.

---

**Signature of Patient or patient representative**

**Date**