COLUMBIA MEMORIAL BONE & JOINT

HIPAA PRIVACY NOTICE

Acknowledgement

I, _____acknowledge that I have been provided with a copy of the Columbia Memorial Hospital's Privacy Notice.

_____	_____	_____
Signature	**Date of Birth**	**Date**

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____hereby grant permission to discuss and/or release my medical information to:

_____	_____	_____
Print Name	**Relationship**	**Telephone Number**
_____	_____	_____
Print Name	**Relationship**	**Telephone Number**

I, _____do _____ do not authorize the permission of my medical information to be left on my voice messaging system when necessary.

_____	_____
Signature Of Patient	**Date**
_____	_____
Witness	**Date**