

Patient Name: _____ **Date of Birth:** _____

Personal Representative and Notice of Privacy Practices Form

Financial Responsibility:

I authorize Far Oaks Orthopedists, Inc. to release any information to the insurance carrier (or to any other person responsible for payment) in order to process my claims. I permit a copy of the authorization to be used in the place of the original. I certify the information I have given to be true and correct. I authorize payment directly to the physician of Far Oaks Orthopedists, Inc. I understand that services not covered by my insurance are my responsibility.

Privacy Practices:

I authorize *Far Oaks Orthopedists, Inc.* to disclose or provide my protected health information to the following individual (s) who is (are) authorized to act as my personal representative for the purposes of receiving all health information about myself. As my designated personal representative (s), they may exercise my right to inspect, copy, and correct my health information. They may also consent or authorize the use or disclosure of my health information (including treatment, payment, and health care operations).

I have received a copy of this office's Notice of Privacy Practices.

Below are my selected representatives:

Name of Personal Representative	Relationship to Patient	Phone Number: Cell Home Work
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Name of Personal Representative	Relationship to Patient	Phone Number: Cell Home Work
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SIGNATURE OF PATIENT/PARENT/GUARDIAN

DATE