NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

LAKEWOOD ORTHOPAEDICS SURGICAL & MEDICAL GROUP

5750 Downey Avenue, Suite 308
Lakewood, California 90712

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

Patient Name _____

Patient Representative _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" for Lakewood Orthopaedics Medical & Surgical Group", but was unable to do so, as documented below:

_____	_____	_____
Date	**Initials**	**Reason**