

***Bellevue Bone and Joint Privacy Act Notice***

Posted in waiting room. Copies available upon request.

Do you give our office permission to leave a message or discuss your medical information with someone other than yourself? YES NO

If yes, please provide their names, relationship and phone numbers.

Name\_\_\_\_\_ Relationship\_\_\_\_\_ Ph \_\_\_\_\_

Name\_\_\_\_\_ Relationship\_\_\_\_\_ Ph \_\_\_\_\_

Do you give our office permission to leave a message on a home recorder?  
YES NO

**By signing below, my signature acknowledges that I understand the Privacy Act and HIPPA law.**

Date\_\_\_\_\_ Patient/Guardian\_\_\_\_\_