ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

GREGORY P. HARVEY, M.D.
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ALAN J. RECHTER, M.D.
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DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M.
JUSTIN CHRONISTER, M.D.

KATHERINE HARRISON
ADMINISTRATOR

NOTICE OF PRIVACY PRACTICES

I have reviewed ORTHOPAEDIC ASSOCIATES, L.L.P.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature____ Date__________________

I hereby give authorization to Orthopaedic Associates, L.L.P. to release any or all of my information regarding my medical records to a designation of my choice:

Name____ Relationship to Patient__________________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature____ Date__________________