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**Acknowledgement of our Notice of Privacy Practices and Consent to Obtain Prescription History**

I agree that California Orthopedics and Spine may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of California Orthopedics & Spine Notice of Privacy Practices. (A laminated copy is available at the front desk. Additionally, I may request a hard copy at any time.) By signing below, I am giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices. I am also authorizing you to release and or discuss my Health Care Information with the following persons:

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| --- | --- |
|  |  |
| Name | Relationship |
|  |  |
| Name | Relationship |
|  |  |
| Patient Name | Date |
|  |  |
| Signature |  |