**MICHAEL O. LAGRONE, M.D., P.A. | ORTHOPAEDIC SURGERY**
Adult and Pediatric Spine Surgery – Scoliosis – Pediatric Orthopaedics
1600 Coulter, Building B, Amarillo, Texas 79106
Phone: (806) 354-2529 | Fax: (806) 354-2956 | www.scoliosismd.com

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

By signing below, you acknowledge that you have received the attached *Notice of Privacy Practices* prior to any service being provided to you by the office of Michael O. LaGrone, M.D, P.A., and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

Patient Name: _____ Patient Date of Birth: _____
(Please Print Name)

**SIGNATURES:**

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

## PATIENT PERMISSION FOR RECORD DISCLOSURE

I hereby give permission to Michael O. LaGrone, M.D., P.A. to disclose and discuss any information related to my medical and financial condition(s) to/with the following:

| Name | Relationship to Patient/Date of Birth | Phone Number |
|---|---|---|
| Name | Relationship to Patient/Date of Birth | Phone Number |
| Name | Relationship to Patient/Date of Birth | Phone Number |

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient, Parent or Legal Guardian Date