Ashay A. Kale, MD ■ Soheil Motamed, MD ■ Ricardo Molina, MD ■ Co V. Banh, MD
Joshua Van Gompel, DPM ■ Gabriel Van Gompel, DPM ■ Erik Schuenke, DPT ■ Sarah Wanlin, DPT
Ava Novotny, PA-C ■ Joshua Ninichuck, PA-C ■ Van Nguyen, PA-C ■ Kelli Kern, PA-C

Orthopaedic Surgery ■ Arthroscopy & Sports Medicine ■ Shoulder & Elbow Surgery ■ Joint Replacement
Podiatry: Foot & Ankle Surgery ■ Physical Medicine & Rehabilitation ■ Interventional Spine Care
■ Physical Therapy

TO OUR PATIENT OR LEGAL REPRESENTATIVE PLEASE READ AND SIGN:

HIPAA COMPLIANCE

As mandated by the Federal Government and office of Civil Rights, Mission Peak Orthopaedic Medical Group is required to follow the **HIPAA Compliance Act to ensure patient confidentiality**. I understand that as part of my healthcare, Mission Peak Orthopaedic Medical Group maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basis for planning my care and treatment; 2) means of communication amount the many healthcare professionals who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-part can verify that services billed were actually provided: 5) a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right: 1) to object to the use of my health information for directory purposes: 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation—and that the organization is not required to agree to the restrictions requested: 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:
In the event that Mission Peak Orthopaedics needs to give your test results or medical information, may we:
Leave a detailed message can be left on my answering machine: □ Yes □ No
Leave a message with my spouse or family member: □ Yes □ No
Call you on your cell phone: □ Yes □ No Cell phone: ____________________
Call you at work: □ Yes □ No Work phone: ________________________

MEDICAL INFORMATION CAN BE DISCUSSED WITH AND RELEASED TO
□ PATIENT ONLY
□ FAMILY MEMBER OR FRIEND:

- NAME ______________________ RELATIONSHIP TO PATIENT: _______________
- NAME ______________________ RELATIONSHIP TO PATIENT: _______________
- NAME ______________________ RELATIONSHIP TO PATIENT: _______________
- NAME ______________________ RELATIONSHIP TO PATIENT: _____________

□ PHYSICIAN: _____________________________________
□ OTHER____________________
□ OTHER RESTRICTIONS_____________________________

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Signature of Patient or Legal Representative