Orthotic Solutions

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Fairfax, VA 22031
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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Orthotic Solutions Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Orthotic Solutions health care operations. The Notice of Privacy Practices also describes my rights and Orthotic Solutions duties, with respect to my protected health information. The Notice of Privacy Practices is located in a white binder in the reception area.

Orthotic Solutions LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Consent to release of Confidential Health Care Information

As the person signing this release, I understand that I am giving my permission to Orthotic Solutions, LLC and/or staff member, to release Medical Information. Please list below all parties that you are authorizing the release of Medical Information to:

Myself ☐ Yes ☐ No

Other Parent /Spouse ☐ Yes Their Name: _____ ☐ No

Other (Please Specify below)

Name	Relationship	Phone Number
Name	Relationship	Phone Number

May we call you at your place of employment? ☐ Yes _____ (Phone Number) ☐ No

May we leave information on your home/cell answering machine? ☐ Yes ☐ No

I understand I have the right to revoke this release, but that my revocation is not effective until delivered in writing to Orthotic Solutions LLC.

Patient Name

_____ _____

Patient/Guardian Signature Date