



Orthopaedic Surgeons

Robert A. Kayal, MD, FAAOS
*Board-Certified Orthopaedic Surgeon
Founder, President & CEO*

Edward C. Friedland, MD, FAAOS
Board-Certified Orthopaedic Surgeon

E. Jeffrey Pope, MD
Board-Eligible Orthopaedic Surgeon

Foot & Ankle Surgeon

Chad W. Rappaport, DPM, FACFAS
Board-Certified Foot & Ankle Surgeon

Podiatrist

Theresa Ronna, DPM
Board-Certified Podiatrist

Physician Assistants

Michael G. Kayal, RPA-C
Chief Physician Assistant

Dean P. Mellas, PA-C

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF KAYAL ORTHOPAEDIC CENTER, P.C.'S
NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH
INFORMATION**

I, _____, acknowledge receipt of KAYAL ORTHOPAEDIC CENTER, P.C.'S (the "Provider") Notice of Privacy Practices dated February 16, 2006 and I consent to the Provider's use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and healthy care operations of the Provider and in accordance with the Notice of the Provider's Privacy Practices. I understand that while this consent is voluntary, if I refuse to sign this consent, the Provider can refuse to treat me.

I also consent to the restrictions contained in the Notice of Privacy Practices regarding all worker's compensation information. I understand that such information will not be disclosed to me without the written authorization of the applicable worker's compensation carrier/payor. In the event that such worker's compensation carrier/payor refuses to release any or all of such records, I hold the Practice and all of its shareholders, physicians, employees and agents harmless in connection with such refusal.

I understand that I have the right to request that the Provider restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent at any time by notifying the Provider in writing, but if I revoke my consent, such revocation will not affect any actions that the Provider took before receiving my revocation.

Signature of patient or patient's representative Date

Printed name of patient or patient's representative

Relationship to patient