



Orthopaedic and Spine Center, LLC
1080 Polaris Parkway, Suite 200
Columbus, Ohio 43240
Telephone: 614-468-0300 ext. 100 Fax: 614-468-0214

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE TO PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Authorization to Release Records

I hereby authorize and direct that the provider listed below release my medical records including a report of patient diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to Patient's treatment, for the purpose of providing medical care to patient to Orthopaedic & Spine Center, LLC:

Name of Provider: _____

Address: _____

Telephone: _____

Fax: _____

I understand that I have the right to inspect the information to be released.

I understand that I may revoke this authorization at any time by notifying the physician listed above in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Orthopaedic and Spine Center, LLC Notice of Privacy Practices.

Patient/Parent or Guardian Signature: _____

Today's Date: _____

_____ Dr. Kedar K. Deshpande, M.D., FAAPMR
_____ Michelle L. Bester, C.N.P.