Orthopedics & Sports Medicine, LLC

Michael L. Gross, M.D.
Chief, Sports Medicine Service
Hackensack Univ. Medical Center
Fellowship Trained Sports Medicine
Board Certified Orthopedic Surgery
and Sports Medicine

Oscar Vazquez, M.D.
Fellowship Trained Sports Medicine
Fellowship Trained Shoulder, Elbow Reconstruction
Board Certified Orthopedic Surgery

A. Ylenia Giuffrida, M.D.
Fellowship Trained in Hand, Upper Extremity
and Microvascular Surgery
Board Certified Orthopedic Surgery

Richard D. Rhim, M.D.
Fellowship Trained, Spine Surgery
Minimally Invasive Spinal Surgery
Board Certified Orthopedic Surgery

James C. Natalicchio, M.D.
Fellowship Trained Interventional Spine Care
Board Certified Physical Medicine
and Sports Medicine

Michael T. Benke, M.D.
Fellowship Trained, Sports Medicine
Board Certified Orthopedic Surgery

Thomas K. John, M.D.
Fellowship Trained, Total Joint Reconstruction
Board Certified Orthopedic Surgery

Ira Esformes, M.D.
Chairman, Orthopedic Surgery
Hackensack UMC at Pascack Valley
Board Certified Orthopedic Surgery
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Board Certified Physical Medicine
and Rehabilitation

Michelle Joseph, P.A.
Physician Assistant

Nicole Jahn, P.A.
Physician Assistant

Sabrina Shahbahrami, P.A.
Physician Assistant

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers that may be involved in my treatment directly and/or indirectly.

- Obtain payment from third party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice or Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions. I understand that request to forward my medical records to another treating physician other than my primary care physician must be made in writing.

Patient Name: _____

Signature: _____

Date: _____

I hereby give permission for the following to obtain any medical information on my behalf:

Name_____ Relation:_____

Name:_____ Relation:_____