

HIPAA

ACKNOWLEDGEMENT

This is to certify that I, the undersigned hereby consent to and authorize the disclosure of any medical information to the following:

- HUSBAND WIFE CHILD PARENT
 OTHER, PLEASE SPECIFY: _____

May we leave a message at the contact number you provided? Yes No

May you be called at your place of employment to be informed of your medical information? Yes No

If you do not want a certain disclosure made to the above, it is your responsibility to notify us.

Thank you for your cooperation.

I HEREBY ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

Witness:

Patient:

Witness Signature

Patient Signature

Date

Print Name