PRIVACY NOTICE ACKNOWLEDGMENT

The signature below acknowledges a copy of this notice was RECEIVED (not necessarily read).

_____ _____

Patient/Legal Representative's Signature Date

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name _____

Below is a list of persons that you give permission for our office to discuss and use the patient's protected health information, including condition and treatment plan, test results, prescriptions, and x-rays:

Name	Relationship to you	Telephone number

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's healthcare information.

_____ _____

Patient Signature/Legal Representative Date