



HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and to provide individuals with the Notice of our legal duties and privacy practices with respect to Protected Health Information.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

By signing this form you are also allowing our office to:

1. Confirm appointments by telephone. Please list the phone number that you prefer us to call: _____;
2. Disclose medical information requested by other treating physicians;
3. Leave messages or discuss medical information with your pharmacist;
4. Disclose medical information to your insurance company;
5. Request medical records and/or medical information when necessary from other physicians or health care facilities

I hereby give permission to disclose health information about me to the following people:
(Please print name on the line provided)

Wife/Husband: _____
 Daughter/Son: _____
 Mother/Father: _____
 Other: _____

In the event of a billing issue, do you give permission for us to discuss your bill with someone other than yourself? YES _____ NO _____

If referred, please provide:

Doctor's name _____ Phone # _____

If yes, please list name(s) _____

I have the right to withdraw or revise my permission at any time, in writing. I understand that I must give 24 hours notice [unless for illness or emergency] to cancel a scheduled appointment or be charged a late cancellation fee.

Print name: _____

Signature: _____ Date: _____