HIPAA DISCLOSURE

I give the following person permission to communicate with the providers and office staff on my behalf; in accordance with HIPAA (Health Insurance Portability and Accountability Act).

HIPPA Representative and Emergency Contact ________________________________

Their Relationship to you _________________

Their Home Phone Number ____________________

Their Cell Phone Number ______________________

Their Work Phone Number _____________________

________________________________ ______________

Patient/responsible party signature Date

PRIVACY STATEMENT

I certify that I have had an opportunity to review and/or obtain my own copy of the practice's Privacy Statement.

Patient unable to sign privacy statement due to: _____________________________

Acknowledgement of Privacy Statement:

________________________________ ______________

Patient/responsible party signature Date