HIPAA

I acknowledge I have been offered or have received the Notice of Privacy Practices.

Signature:_____***Date:***_____

INFORMATION/RESULTS

I authorize information or results may be left on my answering machine or with an individual listed below. You may discuss my information or results with:

_____relationship_____
_____relationship_____
_____relationship_____
_____relationship_____

Signature_____***Date***_____

PRESCRIPTION PICK UP

If I need to have written prescriptions that need to be picked up from the office and am unable to pick it up myself, I authorize you to release it to the following individuals, who MUST provide identification, when picking up.

_____relationship_____
_____relationship_____
_____relationship_____

I understand that this release is valid until I revoke it in writing by signing a new form. I also understand that if I do not want anyone to receive any information on me, that I will not list anyone above. It is my responsibility to make changes to my HIPPA and release when necessary.

Signature:_____

Relationship of person completing for minor child_____

Patient Name:_____