



HIPAA POLICIES AND PRIVACY PRACTICES

I have reviewed this office's privacy policies and authorize the disclosure of my health information as described in the privacy practices notice.

Would you like a copy of our HIPAA Privacy Policies to review: YES NO

Print Name _____

Signature _____ DATE _____

I give the following additional people permission to access my private health information:

1. _____

___ All private health info

___ Limited health information access to: _____

2. _____

___ All private health info

___ Limited health information access to: _____