

**Patient Name** \_\_\_\_\_

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**PRIVACY POLICY/ HIPAA**

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practice you have been given describes these uses and disclosures in detail. When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have been offered a copy of our Notice of Privacy Practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

With whom may we discuss your medical information? \_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Relationship)

**In case of an emergency who would we contact:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

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