PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_______________________________ _______________________

Patient Name (Please Print) Date

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Parent or Authorized Representative (Please Print)

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Signature of Patient or Parent or Authorized Representative

AUTHORIZATION OF RELEASE OF INFORMATION

I authorize the release of information including: diagnosis, treatment, examination results, and claims information/ financial records to:

No one but me.

Spouse Name: ____________________________________

Child(ren) Name: ____________________________________

Other Name: ____________________________________