I understand that my health information is protected and the protection is described by a document entitled Notice of Privacy Practices. This Notice is displayed at our front desk area and I understand I can obtain a copy at any time. My protected health information (PHI) may be used to carry out treatment, payment, or health care operations by phone, fax, or email communication. It is my right to restrict the use and disclosure of my PHI. My doctor is not required to agree to these restrictions.

Print Patient's Name:______________________________ **DOB:**________________

Authorized Signature:______________________________ **Date:**________________

List anyone we are authorized to discuss your personal health information with (family, friends, caretakers):

______________________________ ______________________________

______________________________ ______________________________