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Notice of Privacy Practices

This confirms that you are aware of and have been offered a copy of the HIPPA Policy and Procedures Protection Health Information that went into effect April 14, 2003

Print Name: _____

Sign Name: _____

Today's Date: _____

Witness signature: _____

If unable to reach you may we leave health related messages for you on your

1. Cell phone? Yes _____ No _____ Cell Phone# _____

2. Home phone? Yes _____ No _____ Home Phone # _____

I authorize you to share my medical information with the following:

Please list

Name _____ Phone # _____ Relationship _____

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