Name:_______________________________ Date of Birth:____________________

Address:____

Marital Status: Single Married Divorced Widowed Other

HIPAA Notice of Privacy Practice and Medical Release

When you sign this consent document, you signify that you agree that we can and will use and disclose your heal6th information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. **A Copy of the HIPAA Notice of Privacy Practices will be provided to you upon request.**

I also give permission to share information pertaining to my care to the following person(s):

1: Name ______________________________ **Relationship** __________________________

2: Name ______________________________ **Relationship** __________________________

3: Name______________________________ **Relationship**__________________________

Contact Information

I would like to be contacted by the following:

Phone 1:______________________________ [ ] cell [ ] text [ ] home phone [ ] email [ ] work

Email 2:______________________________ [ ] cell [ ] text [ ] home phone [ ] email [ ] work

Other 3:______________________________ [ ] cell [ ] text [ ] home phone [ ] email [ ] work

By signing this document, you signify that you have read and agree to the statements listed above. You can revoke this agreement in writing at any time prior to treatment. Your signature will remain on file indefinitely, unless revoked by you or your representative.

______________________________________ ______________________________________
Patient Signature or Parent/Guardian Signature Printed Patient's Full Name

Date______________________________ Witness initials _________