Notice of Privacy Policies

Last Name: First Name: Birthdate:

Date: 04/20/2023

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Additional Disclosure Authority & Emergency Contact

In addition to the allowable disclosures described in the Statement of Privacy Practices, in the event of an emergency, I hereby specifically authorize disclosure of my healthcare information to the persons indicated below.

Name/Relationship:

Contact Phone Number: