Patient Name:

Date of Birth:

I agree to allow disclosure of my PHI (including date/time of appointments) to:

___ My spouse_____
(Printed name and phone number)

___ Member(s) of my family_____
_____
_____
(Printed name and phone number)

___ Other _____
(Printed name and phone number)

___ Myself only

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and reviewed the *Notice of Privacy Practices.*

_____
Print Name of Patient or Legal Representative Date

_____
Signature of Patient or Legal Representative Date

_____
Relationship to patient

Authorization to release information via email

By providing your email address, you agree to receive email information about your healthcare, including protected health information.

_____ _____
Signature Date

This does not serve as an Authorization to Release Medical Records

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other(please specify)