

Notice of Privacy Policies
(HIPPA)

Last Name:

First Name:

Date of Birth:

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.

Signature: _____

Date: _____