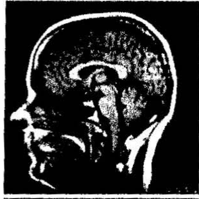

San Jose Pacific Neurology Center
Professional Corporation

NOTICE OF PRIVACY PRACTICES

I, ____________________________, acknowledge being given the **Notice of Privacy Practices** to read and offered a copy of the documentation for my records.

_______________________________________   ______________

PATIENT'S SIGNATURE   DATE

I hereby authorize the physicians and staff at San Jose Pacific Neurology Center to release information regarding my medical care, treatment, and/or appointment to the following individuals as needed:

Please use this portion to indicate the names of any family members or friends only.

________________________________   Phone: (   )   -
Name

________________________________   Phone: (   )   -
Name

________________________________   Phone: (   )   -
Name

_______________________________________   ______________

PATIENT'S SIGNATURE   DATE