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PRIVACY PRACTICE ACKNOWLEDGEMENT (HIPAA)
AND RELEASE OF INFORMATION FORM

I, _____, have reviewed the Notice
(please print full name)

of Privacy Practices (HIPAA).

In addition to this, I authorize my medical information to be released to the person(s) listed below:

Name: _____ Relationship _____

Name: _____ Relationship _____

I understand that by granting this release of information, the person who obtains this information may disclose it to other individuals with or without my consent and in doing so, the information would no longer be protected under HIPAA.

Patient Signature: _____

Date: _____