I understand that under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

Please indicate below any individual or agency that we may discuss your healthcare information with or release medical information to.

____
Name | Relationship | Phone

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Name | Relationship | Phone

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Name | Relationship | Phone

Patient Name: ____

Signature: ____

Date: ____