Privacy & HIPPA Notice

Please list the family members or significant others, if any, whom we may inform about your medical condition or release information to.

Name:_____ Relationship_____
Phone #_____

Name:_____ Relationship_____
Phone #_____

Name:_____ Relationship_____
Phone #_____

Name:_____ Relationship_____
Phone #_____

Signature of Patient:_____

File Signed Copy of this Page with Patient's Record