NOTICE OF PRIVACY PRACTICE

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

You may share any information about my health and conditions with:

_____

_____

REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION

You may request to receive confidential communications involving your protected health information (PHI) by an alternative means or an alternative address. We may not ask you the reason for your request. We will accommodate all reasonable requests.

Answering machine phone number: _____

Fax number: _____

Signature of patient or representative: _____

Relationship to patient: _____ Date: _____

Witness: _____ Date: _____