Notice of Privacy Policies

Last Name: . First Name: . Birthdate: 01/01/0001

Date: 10/26/2017

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Patient/ Parent/ Legal Guardian Signature