
**Patient Privacy**

We are required by law to protect the privacy of you medical information. We are not allowed to discuss or disclose information without your permission. This includes discussing billing or payment information as well as medical information.

By signing this for, you authorize our office to verbally discuss information regarding you and your services at our office with the individuals listed below. This is not a release of your medical records.

Please list below anyone that you would like us to be able to share this private information with. This may include your spouse, children and other family members who may be involved in your care.

If you do not want us to be able to verbally communicate with anyone regarding your services at our office, please sign and decline below.

Personal Contacts:

Name _____ Relationship _____

Name _____ Relationship _____

**Patient Signature _____ Date _____**

_____Declined