NOTICE OF PRIVACY PRACTICE

Protecting your confidential health information is our priority.

Patient Name : _____

Date: _____

I have had full opportunity to read and consider the consent of the Notice of Privacy Practice. 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.

Signature of PATIENT, PARENT, of GUARDIAN: _____

DATE: _____