



RE: Patient Privacy

We are required by law to protect the privacy of your medical information. This means that we are not allowed to discuss any of your medical information with anyone other than yourself. This statement refers to personal *and* professional sources, unless there is continuity of care. If there is anyone that you would like us to share this private information, please fill in the following information. This form will remain in effect until the undersigned has removed the authorization in writing or by completing an updated form. **This form does not allow the production or release of medical records.**

Personal Contacts:

1.
Name Relationship Phone #

2.
Name Relationship Phone #

Professional Contacts:

1.
Name Specialty

2.
Name Specialty

Patient Name:

Chart # _____

Signature Of Patient Or Guardian

Date

Declined

Please complete signature area if declining also