

**PATIENT PRIVACY POLICY**

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the following notice.

We will require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care we provide to you and the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

PLEASE BE AWARE THAT YOU MUST GIVE US YOUR AUTHORIZATION TO SPEAK TO YOUR INSURANCE COMPANY. WITHOUT YOUR AUTHORIZATION WE WILL BE UNABLE TO PROVIDE NECESSARY INFORMATION FOR BILLING AND YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. INFORMATION RELEASED TO INSURANCE COMPANIES IS LIMITED TO ITEMS DIRECTLY RELATED TO SERVICES OUR OFFICE PROVIDES.

Please circle below to whom you would like to release your personal medical information:

My spouse

My insurance company

My family members

My doctors

Other (please list specifically)

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**ABOVE AUTHORIZATIONS ARE REVOCABLE AT ANY TIME**

\_\_\_\_\_  
Printed Name of Patient/ Guardian

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date