# NOTICE OF PRIVACY POLICY
# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
# HIPAA

**PATIENT AUTHORIZATION FORM**

I hereby authorize and acknowledge that I have read and understand the HIPAA Privacy Policy. Any questions have been answered to the best of the Privacy Officer's knowledge. I may receive a paper copy of the Privacy Policy if I do so request.

Patient Name:____________________________________________________

Minor Family members of above patient:

____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

Signature:_______________________________________________________

Relationship of any listed Family Members:___________________________

Date: _____/_____/_____