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 First Name
-

Patient Last Name
-

Minor Family members of above patient:
-

Signature: (ESign)

Date :

Relationship of any listed Family Members:
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