Acknowledgement and Agreement:
For Release & Use of Patient Information

I, _________________________________, do hereby acknowledge I have read, understand and agreed to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_________________________________ _______________________
Signature of Patient/Guardian Date

Acknowledgement and Agreement:
Additional Information Disclosure Form

I, _________________________________, do hereby acknowledge I have read, understand and agreed to the terms set forth in the ADDITIONAL INFORMATION DISCLOSURE FORM. If I have any exceptions to the agreement they are listed below.

Exceptions:

#________ #________ #________

#________ #________ #________

_________________________________ _______________________
Signature of Patient/Guardian Date

Acknowledgement and Agreement:
Protocol for Preservation of Patient Records

I, _________________________________, do hereby acknowledge I have read, understand and agreed to the terms set forth in the PROTOCOL FOR PRESERVATION OF PATIENT RECORDS. I agree to inform the office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the office may comply with all statutory notification requirements to me by regular mail to my indicated address on file.

_________________________________ _______________________
Signature of Patient/Guardian Date