Acknowledgment Of Receipt Of Notice Of Private Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature Date

Authorization for Release of Information

Name of Patient_____ Date of Birth_____

The office of Dr. Bartoo Martin is authorized to release protected health information about the above named patient to the entitles named below. The purpose is to inform the patient of others in keeping with the patient's instructions.

Entity to receive information but not limited to the following; Voice mail, E-mail, Spouse, Parent, Insurance company and other.

Other (provide name and relationship) _____

Description of information to be released; Date and time of appointment(s)

Patient Information-

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document. I understand that I revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in effect until revoked by the patient.

_____

Signature Date