Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

PERMISSIONS (OPTIONAL)

I give permission for _____ who is my _____ to obtain information,
(Name) (Relationship to you)

results, and any inquiries regarding my health information, appointments and billing information.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____.