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**CONFIDENTIAL COMMUNICATIONS
REGARDING YOUR HEALTH INFORMATION**

The confidentiality of your personal health information is of the utmost importance to our office. Please indicate below any requests for restrictions on how we may communicate your personal health information and/or billing information. If this form is left blank, then our office will only disclose information to you.

Please be specific and list names of family members, guardian, spouse, children, etc.

Person(s) who we **are permitted** to discuss your personal health information and/or billing information:

NAME	RELATIONSHIP
_____	_____
_____	_____

This authorization will remain valid until you advise of changes. It is the responsibility of the patient to notify the office of any changes to this information.

Print Name: _____ Date: _____

Signature: _____

Signature below is acknowledgement that you have received a copy of the HIPAA Notice of Privacy Practices:

Signature: _____

Signature below is acknowledgement that you have read and received a copy of our Financial Policy and agree to adhere to it:

Signature: _____