



This notice is effective as of: _____ / _____ / _____

I have read the Privacy Notice and understand my rights contained in the Notice.

By way of my signature, I provide this facility with my authorization and my consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (please print)

Patient's Signature

Date

Authorized Signature

Date