<u>**Protected Health Information**</u>

I Acknowledge that the notice of privacy practices is available. (If you would like a copy of the privacy practices, please request one at the front desk)

We cannot discuss your protected health information with anyone other than yourself,unless you authorize us to do so.

You **ARE NOT** required to list any names if you do not choose. By listing names, you authorize **Dr.Taisenchoy-Bent's Office** to release or discuss information related to your health condition (including information related to your treatment plan,medication information , and/or billing information). Your protected health information will be disclosed to the individual (s) listed below until you notify us otherwise in writing. This authorization will remain in effort for one year.

1.________________________________ Relationship:____________________________

2.________________________________ Relationship:____________________________

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.

Please provide your preferred contact number where you would like us to contact you for test results, appoitment reminders, or changes to scheduled appoitments.____________________________

May we leave a detailed voicemail? Yes__________________ No__________________________

I have read and understand the above Office and Financial Policy and agree to meet all financial obligations.

Patient Signature____________________________ Date__________________________