HIPAA PATIENT RESTRICTION

(MUST BE FILLED OUT IN BLACK INK)

Please list individual(s), friends or family, if any, who you would allow any medical information released to. This authorization will allow the release of any and all medical and billing information to the individuals listed on this form. It is not necessary to list your physician offices here.

1. _____

2. _____

3. _____

Please let us know how you heard about our office…

_____

_____

Authorized signature (Please sign in black ink) Date

Thank you!