



Treatment Authorization and Acknowledgement of Privacy Practices

Authorization for Treatment

I hereby consent to treatment by _____ and/or their staff for all procedures as deemed necessary by the staff and myself.

Acknowledgment of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices of _____ I understand the Privacy Practices as outlined in the Notice of Privacy Practices. I have had a chance to discuss the Notice with Office Representatives and my questions have been answered. Unless stated otherwise below, by signing this consent form I do not object to and have not requested any limitations on any uses or disclosures of my healthcare information. I understand that I may change the status of this authorization at any time by providing written notification to this office.

Signature _____

Print _____

Relationship to Patient _____

Date _____

I request the following restrictions on uses and disclosures of my healthcare information:
