

## Notice of Privacy Practices

This notice effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

I have read the Privacy Notice (a copy of which was provided to me in the office) and understand my rights contained in this notice.

By way of my signature, I provide Peter E. Franklin, M.D. with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

If this authorization form is signed by a personal representative for the individual patient or a guardian:

\_\_\_\_\_  
Representative's Name (print)

\_\_\_\_\_  
Signature of Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Relationship to Individual \_\_\_\_\_