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 _____