



**Acknowledgement and Agreement:
For Release & Use of Patient Information**

I, _____, do hereby acknowledge I have read, understand and agreed to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature of Patient/Guardian

Date

**Acknowledgement and Agreement:
Additional Information Disclosure Form**

I, _____, do hereby acknowledge I have read, understand and agreed to the terms set forth in the ADDITIONAL INFORMATION DISCLOSURE FORM. If I have any exceptions to the agreement they are listed below.

Exceptions:

_____ # _____ # _____

_____ # _____ # _____

Signature of Patient/Guardian

Date

**Acknowledgement and Agreement:
Protocol for Preservation of Patient Records**

I, _____, do hereby acknowledge I have read, understand and agreed to the terms set forth in the PROTOCOL FOR PRESERVATION OF PATIENT RECORDS. I agree to inform the office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the office may comply with all statutory notification requirements to me by regular mail to my indicated address on file.

Signature of Patient/Guardian

Date