

Sharon E. Selinger M.D. & Matthew L. Surgan, M.D.

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Sharon E. Selinger M.D. & Matthew L. Surgan, M.D. Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Sharon E. Selinger M.D. & Matthew L. Surgan, M.D., for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Print Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

[] Check here if you do not wish voice messages to be left on your answering machine or voicemail.

Daytime phone number: _____

II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Sharon E. Selinger M.D. & Matthew L. Surgan, M.D. may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care. I designate the person(s) listed below as individual(s) involved with my health care provided by Sharon E. Selinger M.D. or Matthew L. Surgan, M.D. for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request.

Print Name (and relationship)

Date of Birth: _____

Print Name (and relationship)

Date of Birth: _____

Print Name (and relationship)

Date of Birth: _____

Signature of Patient/Parent/Guardian

Date