By signing this form, I acknowledge that I have reviewed and agree to the Practice's use and disclosure of my protected health information for the purposes set forth within this Authorization

_____

Signature of Patient or Representative

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____

Date

A COPY OF THE COMPLETED AND SIGNED AUTHORIZATION FORM HAS BEEN PROVIDED TO THE PATIENT OR REP.

_____YES **_____NO**

_____

Signature of Authorized Clinic Representative

_____

Date