Dr. Matthew H. Conrad

Acknowledgement of HIPAA Notice

Permission to Disclose information to Those Involved in My Care

I hereby authorize **Dr. Matthew H. Conrad** to disclose the following Protected Health Information (PHI):

____ Appointment times and dates

_____ Other Health Information

____ Test Results

I hereby authorize Dr. Matthew H. Conrad to release and receive medical information from the following persons and or agencies (i.e. family, friends, assistants, therapist etc ....)

Name	Phone Number	Fax Number

Email Consent: email address: ____

By providing an email address, I attest that I control access to its information. This office cannot guarantee the security and confidentiality of email communications. Dr. Conrad's office does not use encryption software as a security mechanism for email communications. I understand that I may revoke this authorization at any time by providing **Dr. Matthew H. Conrad's** office with a written notice**. Email will only be used for purpose of before and after photos or for records requested by the patient themselves**. I understand that electronic communication should NOT be used in the case of an emergency.

Lab Choice: ________________________________

Pharmacy Choice: ___________________________

Patient Signature: ____________________________ Date ____________________________

Patient Printed Name: ____