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HIPAA ACKNOWLEDGEMENT

I hereby acknowledge that I have had the opportunity to review and/or receive a copy of HIPAA Notice of Privacy Practices for Michelle L Pepper, MD.

AUTHORIZATION

My signature below authorizes the staff of Michelle L. Pepper, MD to verbally (by telephone or in person) share all of my medical information without limitation with the following individuals:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Print Name:_____Date of Birth:_____

Signature:_____Date:_____

This form does not entitle these persons to copies of medical records. Consent expires with the end of my care with Michelle L. Pepper, MD