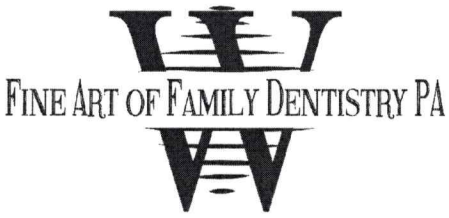

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE: This form is used to obtain written acknowledgement of receipt of our Notice of Privacy Practices.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date_____

AUTHORIZATION TO RELEASE INFORMATION

PURPOSE: This form is used to obtain authorization to release information regarding yourself covered under the privacy act to people other than yourself. This allows us to discuss appointments, treatments or finances as you designate.

I, _____, authorize the following person (s) to have access to information covered under Privacy Practice regarding myself.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____