PATIENT LEGAL NAME: ___________________
DATE OF BIRTH: _______/_______/______

PATIENT CONTACT INFORMATION SHEET

Any physician, staff, employee, or representative of Dysautonomia-MVP Center has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

PATIENT'S SIGNATURE: DATE:

All patients 14 years and older are required to sign. Parent and/or guardian may sign for patients 13 years old or younger.

<u>OR</u>

I do not want anyone to have access to my protected health information.

PATIENT'S SIGNATURE DATE:

I give permission to leave a message on ________________________________ line.

PATIENT'S SIGNATURE: DATE:

I have received a copy of the HIPAA Notice of Privacy Practices for Dysautonomia-MVP Center, LLC.

PATIENT'S SIGNATURE: DATE: