Bryan Davis, M.D.
FAMILY MEDICINE

I have read Dr. Davis' "Notice of Privacy Practices"

Patient name: _____

Patient or Legal Guardian Signature: _____

Date: _____

I have read Dr. Davis' Financial Policy

Patient name: _____

Patient or Legal Guardian Signature: _____

Date: _____

Authorization to Release Medical Information to Individuals or Family Members

In accordance with Federal Government privacy rules implemented through the healthcare provider portability act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I do not authorize the practice to release any or all information concerning my medical care to any individual except as set forth above.

____ I authorize the practice to verbally release any or all information concerning my medical care to the following individuals.

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

Patient or Legal Guardian Signature: _____

Date: _____