ALEXIUS M. BISHOP, M.D., P.S.C.

Pediatric and Adolescent Medicine

NOTICE OF PRIVACY PRACTICES / HIPAA

18 AND OVER PATIENT AFFIRMATION

I, ______________________________, hereby acknowledge that I was given a copy of the Notice of Privacy Practices issued by Alexius Bishop, M.D., P.S.C. on the date indicated below.

I am a patient over the age of 18 and realize that Alexius Bishop, M.D., P.S.C. cannot release my medical information without my permission. Therefore,

____ I authorize Alexius Bishop, M.D., P.S.C. to release medical information to parents

____I do not authorize Alexius Bishop, M.D., P.S.C. to release medical information to parents

My Personal Contact #: __________________________________

___________________________________ Signature

___________________________ Date

____________________________________ Printed or Typed Name

___________________________ Social Security #

(Completed by office staff)

____________________________________ Witness

___________________________ Date