HIPAA Notice of Privacy Practices Signature Page
for
William Bryan Bell, M.D.

Date: _____

**If asked, does our office have permission to give the appointment date/time to any member of your family? YES NO

If YES, Name:_____ Relationship: _____

PHONE NUMBER FOR REMINDER CALLS: _____

**I have read or am aware of the HIPPA Notice of Privacy Practices for Dr. Wm. Bryan Bell and ACCEPT the policy.

Client Name: _____ Signature: _____
(Client or Guardian)

* * * * *

I have read the HIPPA Notice of Privacy Practices for Dr. Wm. Bryan Bell and have the following **restrictions and / or amendments** to request. (Only complete if this section applies):

_____
_____
_____
_____

Signature: _____
(Client or Guardian)

* * * * *

Additionally, I agreed to authorize communication between Dr. Bell and/or his staff with my primary care physician, if needed: YES NO

NAME of Primary Care Physician: _____

Signature: _____
(Client or Guardian)