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)