PRIVACY CONSENT

Please answer ALL of the following questions:

Do we have permission to:

	YES	NO	N/A
Leave a message on your answering machine at home?	____	____	____
Leave a message at your place of employment?	____	____	____
Send/receive medical information to/from consulting Physicians?	____	____	____
Discuss medical conditions with any member of your Household? If yes, whom?______________________	____	____	____

This notice is effective April 14, 2003. Any alterations or amendments made hereto will expire seven years from the date upon which the records were created. My signature below acknowledges that I have been offered to receive a copy of the privacy notice.

___________________________	___________________________	___________
Patient Name (print)	Signature	Date

If patient is a minor, or being represented by another party:

___________________________	___________________________	___________
Parent/Guardian Name (print)	Signature of Parent/Guardian	Date