

**Clinic Name**

**Clinic Address**

**Clinic Phone Number**

Privacy Agreement

1. I authorize the health care professionals who treat me through clinic name to discuss any and all patient information about me and my treatment, medical condition or related topics to visiting clinicians, healthcare professionals, and care-related vendors.
2. I release clinic name from any and all state or federal statutes relating to patient privacy.
3. I specifically authorize officials from clinic name to discuss my care (or my child’s case, or an individual to whom I provide guardianship), with these individuals.
4. Any release of original or copies of records will require my written authorization.

Patient Name: insert

Date of Birth: insert

Telephone Number: insert

Date of Clinic Visit: insert

*Patient Signature*

Patient Printed Name