Family Physicians Of Laramie, LLC.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Family Physicians of Laramie Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Family Physicians of Laramie may disclose and use my protected health information.

Patient Name:_____ Date of Birth:_____

Signature: _____ Date of Signature: _____

If signed by the patient's personal representative, indicate:

a. Name of signer:_____

b. Relationship to patient: _____

If acknowledgment not signed, indicate reason not signed and efforts made to have acknowledgment signed:

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Family Physicians of Laramie, LLC to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that Family Physicians of Laramie, LLC may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist or other health care provider who is involved in my care.

Family Physicians of Laramie may leave messages (for appointment reminders, Lab or x-rays results) on my telephone answering machine **at my home**. _____ Yes _____ No

Family Physicians of Laramie may leave messages (for appointment reminders, Lab or x-ray results) on my telephone voice mail **at my work**. _____ Yes _____ No

If necessary, Family Physicians of Laramie may talk **with my spouse or significant other** about my medical condition and / or billing information. _____ Yes _____ No
The name of this person is _____

If necessary, Family Physicians of Laramie may talk **with my parent(s) or with my caretaker** about my medical condition and / or billing information. _____ Yes _____ No
The name of my Parent(s) or caretaker are: _____

Family Physicians of Laramie **MAY NOT** discuss my medical condition with: _____

Rights of the Patient:

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: **Family Physicians of Laramie, LLC 2710 Harney Street, Suite 100 Laramie, WY 82072.** I understand that any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

Signature: _____ Date:_____