Patient Privacy Policy

Because we respect your privacy, it is our policy to disclose information regarding your health and account status with you alone. If you would like us to share information with parties other than yourself, please supply us, in writing, the names below:

Name: Relationship:

1._____
2. _____
3. _____
4. _____
5. _____

Authorization for Treatment of a Dependant

As the legal parent/guardian of _____, I authorize Dr. Elliot Michael, Dr. Gina Bullock or Dr. Gary Chiotti to treat this patient for their current, as well as future, medical needs and accept all financial responsibility.

Guardian Social Security #:_____ Relationship:_____

Guardian Printed Name:_____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____