JASSER CENTER
FOR COMPREHENSIVE CARE

Health Insurance Portability and Accountability Act (HIPPA)

Patient Name: _____ Date of Birth: _____
(Please print)

Consent: (check one)

____ I authorize Jasser Center for Comprehensive Care, to disclose my medical information to the following person(s). I understand this consent is valid for one year from the date of this consent form.

Please list no more than two names:

Name	Relation to Patient	Phone Number	May receive information
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

____ I do not authorize Jasser Center for Comprehensive Care to disclose my medical information to anyone other than to comply with the Privacy Practices.

Signature of Patient or Guardian _____

Printed Name of Patient or Guardian _____

Date _____