

**THE EFIRD CLINIC
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM THE EFIRD CLINIC.

PATIENT SIGNATURE

DATE

AUTHORIZATION TO RELEASE APPOINTMENT/REFERRAL INFORMATION

I hereby authorize the physicians and/or staff of THE EFIRD CLINIC to release appointment, referral information, and prescription refill request information as indicated below.

_____ Information may be left on the home or work answering machine requesting that I call the office.

_____ Information may be shared with the following individuals: (Please list all names that apply, and their relationship to you)

I understand that this authorization will be maintained in my medical record. I have the right to update this authorization at any time by submitting a request in writing signed by me.

I hereby give providers of THE EFIRD CLINIC my permission to provide treatment for me as medically necessary.

SIGNATURE

DATE