HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Manager in person or by phone.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the office of Salvatore A. Barbaro III M.D., P.A. to disclose my medical information to:

NAME:	**RELATIONSHIP TO PATIENT:**
_____	_____
_____	_____
_____	_____

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____