PRIVACY PRACTICES ACKNOWLEDGEMENT

George Lian, M.D.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____

We strive to maintain the privacy and integrity of your medical record, also referred to as Protected Health Information (PHI). Under no circumstances do we disclose personal or medical information about you unless authorized by you or mandated by law.

As a patient, you have the right to determine who may receive medical information about you from our office. Some patients select no one other than themselves to receive information, while others elect special family members or friends who may receive their information. In order to assure PHI continues to be secure, please take a moment to answer the questions below.

Please list the first and last name of any individual allowed to receive your Protected Health Information. Please limit the list to three people. If no one other than you is allowed, please list "Self Only":

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your Name: _____ Date: _____

Signature: _____

If you wish to change this information at any time please ask for another form. Thank you.