

PATIENT CONSENT FORM TO OTHER ENTITIES

I am aware that this office may make referrals to another physician, laboratory, or for other testing.

- I give permission**
 I do not give permission

to Dr. Gary D. Salomon to release my Personal Health Information to such entities to further my care.

PATIENT RIGHTS TO PRIVACY RULES

As a patient of Dr. Gary D. Salomon you have a right to know how your Personal Health Information may be used. You have a right to review our HIPAA Compliance Manual. You have a right to know your Privacy Right. You have a right to file a complaint to the office designated Compliance Office. You have a right to get answers to your questions and concerns.

I certify that the Privacy Rules, Notice of Privacy Practices for Patient Health Information and HIPAA Compliance Manual were made available to me.

Patient Signature: _____

Date: _____

Witness: _____