Jacqueline Azelvandre, D.O. & Associates, LLC

301 S. Milwee Street Longwood, FL 32750
Phone: (407) 339-1060 Fax: (407) 339-1081

Patient Name: ____ Date of Birth: ________________

Acknowledgement of Privacy Practices

A copy of the Azelvandre, D.O. & Associates Notice of Privacy Practices is in a white binder located in our waiting room next to the check in window for you to review at any time.

If you would like a copy of the Notice of Privacy Practices, please ask the front desk receptionist.

I herby acknowledge that I have been informed and/or received a copy of Azelvandre, D.O. & Associates, LLC Notice of Privacy Practices as required by law.

____________ ____

Date Patient Signature

HIPPA Authorization for use and disclosure of Protected Health Information

I authorize the office of Dr. Jacqueline Azelvandre, D.O. to disclose protected health information to the following:

PRINT NAME AND RELATION OF PERSON(S) AUTHORIZED TO RECEIVE INFORMATION:

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Please circle one: **I DO / DO NOT** authorize the office of Dr. Jacqueline Azelvandre to leave telephone messages regarding my protected health information on the voicemail or answering machine.

Patient Signature: ____ Date: ________________