I AUTHORIZE DR. THOMAS D. BIANCHI AND/ OR HIS STAFF TO COMMUNICATE MY PRIVATE MEDICAL INFORMATION TO THE FOLLOWING PERSON(S):

1. _____ **2.** _____

3. _____ **4.** _____

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____
PRINT PATIENT NAME DATE

_____
SIGNATURE OF PATIENT OR GUARDIAN

_____
PRINTED NAME OF PATIENT'S GUARDIAN

_____
RELATIONSHIP TO PATIENT

TO BE COMPLETED BY PHYSICIAN'S OFFICE

After a good faith attempt to obtain an acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s).

_____ _____
Signature of Health Care Provider Date