NOTICE OF PRIVACY PRACTICES

By signing this form, you are granting consent to Dr. James M. Cooper to use and disclose your protected health information for the purpose of treatment, payment, and health care operations (TPO).

Summary of our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your (IIHI). By federal and state law, we must follow the terms of the *Notice of Privacy Practices* that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

-How we may use and disclose your **IIHI**

-Your privacy rights in your **IIHI**

-Our obligations concerning the use and disclosure of your **IIHI**

A copy of the *Notice Of Privacy Practices* is available to our patients at any time.

In keeping with our commitment to protect your privacy, please indicate below whom you would allow us, Dr. James M. Cooper, to release any medical information, financial information, and/or discuss your treatment with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give Dr. James M. Cooper permission to contact me at the address, home phone, cell phone, work number and email, where applicable, that I have provided. If necessary, a message may be left on my home answering machine, cell phone or work number if I've authorized this.

Any exclusions: _____

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____