Notice of Privacy Practices – Consent to Share

We at Matthews-Vu Medical Group, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following: ***(please print)***
Patient Name ____ Date of Birth: ____________

Preferred Contact number(s): May we leave a detailed message? Y N ***(circle one)***

Home: ______________________ Cell: _______________________ Work: ___________________
Yes No Yes No Yes No

Please list the people that we have your permission to discuss your medical records and are allowed to have a copy of your information:

Name of person(s)/Relationship	Date of Birth	Phone Number (if available)

This authorization applies to the following information: ***(please initial):***
All Records ________ Labs ________ Imaging Records ______ Immunizations ________

I have been made aware and have had the opportunity to review the privacy policies of Matthews-Vu Medical Group.

Patient/Guardian Signature: _______________________________ Date: ___________________

Print Name: ____