HIPAA PRIVACY STATEMENT

Patient Name: _____ Date of Birth: _____

By signing below, I acknowledge receiving a copy of *Dr. Jeffrey A. Schiappa's Notice of Illinois Privacy Practices* (dated April 14, 2003)**, that details how my information may be used and disclosed as permitted under federal and state law. I request the following restrictions concerning the use of my personal information:**

_____

_____

_____ _____

Signature of Patient, Parent/Guardian or *Personal Representative **Date**

** If signed by a Personal Representative, please include the following information:*

_____

Personal Representative Name

_____

Description of Personal Representative's authority to act on behalf of patient

EMPLOYEE USE ONLY:

If Patient refuses to sign, indicate your attempt to obtain signature below:

_____ _____

Employee Name Time

_____ _____

Employee Signature Date

Jeffrey A. Schiappa D.O.

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