Zand
Medical Partners

NOTICE OF PRIVACY PRACTICE

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign an **acknowledgement** receipt of this brochure.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

You are authorizing Zand Medical Partners to share your health information with:
(Please list names of person and/or facility)

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____