

## HIPPA Statement of Understanding

*If you would like to allow someone else (parents, a spouse, caretakers, etc.) to have access to your medical information you must indicate that on this form.*

Is there anyone you would like to have access to your medical information?                      YES                      NO

If YES, please list names and their relationship to you here:

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Please **INITIAL** the following statements to indicate you have read and understand them:

\_\_\_\_\_By signing below you agree that the above information has been provided by you, and is correct and complete. You understand this information will only be used for your personal medical record in the office of Dr. Christopher L. White, GREENBRIER VALLEY E.N.T., PLLC. The above information you have provided will not be sold and will not be shared for any purpose other than further medical treatment or care.

\_\_\_\_\_By signing below you agree you have read and understand the HIPPA notice of privacy policy that we following our practice. You understand we only provide your medical information to individuals you have listed above, or to providers including other doctors or laboratory services. You may specify any further instructions on this form.

\_\_\_\_\_By signing below you acknowledge this form may be modified and re-submitted by you at any time. Once this form is signed and submitted it becomes part of your permanent record and will be effective until you make changes or until the time of your death.

If you have any questions about this information or form, please ask to speak with our Office Manager:  
Laura Testerman, R.N. (304) 645-0870 x113.

Patient Printed Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_