Evansville Primary Care Privacy Statement

By signing below, I, _____________________________________, acknowledge receipt of the Notice of Privacy Practices as required by the HIPAA regulations from Evansville Primary Care.

I give Evansville Primary Care permission to share/release my protected health information to the following people:

____________________________________	______________________________
NAME	**RELATIONSHIP TO PATIENT**
____________________________________	______________________________
NAME	**RELATIONSHIP TO PATIENT**
____________________________________	______________________________
NAME	**RELATIONSHIP TO PATIENT**

____ ______/_______/_______

PATIENT/RESPONSIBLE PARTY SIGNATURE **TODAY'S DATE**

-------------------For Treatment of Minors Only-------------------

In the case that parent or responsible party cannot be present for appointments, the following person(s) have permission to bring __________________________ in for any medical treatment needed. Please list name followed by relationship to the patient.

_________________/_________________ _________________/__________________

_________________/__________________ _________________/__________________

Evansville Primary Care
evvprimarycare.com
4933 Plaza East Blvd
Evansville, IN 47715
T: 812.479.6907
F: 812.479.6967

Revised October 2018