

PRIVACY ADDENDUM

I understand that my private health information will only be released as needed for treatment, payment and healthcare operations. However, I authorize the following person(s) (spouse, significant other, parent, child, etc.) to have access to my test or lab results, to be included in discussions with my physician, to be able to call in and discuss my health or billing history, and/or be present with me during an examination:

This authorization will expire one year from the signing date or upon my written request.

Patient

Date