Brent H. Taylor, M.D., F.A.C.S.
2490 S. Woodworth Loop, Suite 400
Palmer, AK 99645
(907) 745-9400
(907) 745-9444 fax

Receipt Acknowledgement of HIPAA and Billing Information Practices
And
Additional Specific Releases

Patient Name_____ DOB_____

I give the office of Brent Taylor, MD permission to discuss/disclose my health information with the persons identified below:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

I acknowledge that I was provided a copy of the **Notice of Health Information Practices** and understand that this acknowledgement will become a permanent part of my medical record.

_____ _____
Signature Date

Notice of Privacy Policies Revision Number 1 (2003)