Hope ND LLC

Health Information Consent

I give my consent to representatives of Hope ND LLC to leave messages on my home answering machine system, email, or with individuals that I will designate below.

Relating to my care (please circle): YES NO

Appointment Reminders (please circle): YES NO

I give my consent to representatives of Hope ND LLC to discuss my care with the following individuals:

Name/Relationship: _____ Phone:_____

I understand and agree that this authorization will stay in effect until such time I give written notice to change or withdraw my authorization

Signature:_____Date:_____

Notice of Privacy Policies – Acknowledgement of Receipt

I have received a copy of the HIPAA Privacy Policies that explains my rights and documents policies and procedures that will safeguard my private health information.

Signature:_____Date:_____