Matthews-Vu
Healthcare for Children and Adults

Notice of Privacy Practices – Consent to Share

We at Matthews Vu Medical Group, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

To assist us in protecting your privacy, please complete the following:

_____ _____
Patient Name Date of Birth

Preferred contact numbers: May we leave a detailed message? Y N (circle one)
Home: _____ Cell: _____ Work: _____

Y N Y N Y N

Please list those that we have your permission to discuss your medical records and are allowed to have a copy of your information:

Name/Relationship:	Date of Birth	Phone number (if available)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization applies to the following information (please initial):

All Records _____ Labs _____ Imaging Records _____ Immunizations _____

I have been made aware, and have had the opportunity to review the privacy policies of Matthews-Vu Medical Group.

_____ _____
Patient/Guardian Signature Date

Print Name: _____