MICHAEL A. DEROSA, D.O.
MARY LOU DALE, PA-C
3694 Starrs Centre Drive
Canfield, Ohio 44406
PHONE 330-702-1310
FAX 330-702-1344

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED HEREBY CONSENT TO AND AUTHORIZE THE DISCLOSURE OF ANY MEDICAL INFORMATION TO THE FOLLOWING:

HUSBAND ☐ **WIFE** ☐ **CHILD** ☐

NIECE ☐ **NEPHEW** ☐ **GRANDPARENTS** ☐

PARENTS ☐

OTHER: PLEASE SPECIFY_____

MAY YOU BE CALLED AT YOUR PLACE OF EMPLOYMENT TO BE INFORMED OF YOUR MEDICAL INFORMATION?

YES ☐ **NO** ☐

IF YOU DO NOT WANT A CERTAIN DISCLOSURE MADE TO THE ABOVE, IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE. THANK YOU FOR YOUR COOPERATION.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

WITNESS_____ **DATE**_____

PATIENT_____**DATE OF BIRTH**_____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE NO.: _____

(OVER)

RECEIPT- NOTICE OF PRIVACY PARACTICES

MICHAEL A. DEROSA, D.O.

Dr. Michael A. DeRosa respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice o Privacy Practices describes potential uses and disclosures of your health information by our practices and outlines your medical privacy rights.

Please sign below and return this form to the receptionist or medical assistant so that we know you have received our Notice of Privacy Practices.

DATE: _____

PATIENTS NAME (PLEASE PRINT) _____

SIGNATURE: _____

NAME OF PERSON OR REPRESENTATIVE (PLEASE PRINT):

_____

SIGNATURE OF PERSONAL REPRESENTATIVE:

_____

FOR OFFICE USE ONLY BELOW THIS LINE

Office Use Only:

_____ Patient refused to sign

_____ Patient unable to sign

_____ Does not apply in emergency situation

_____ Staff initials