

**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.**

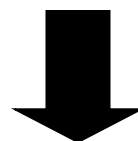
**WITNESS** \_\_\_\_\_ **DATE** \_\_\_\_\_

**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