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PRIVACY POLICIES

I hereby consent to the use and disclosure of my protected health information by Dr. Kellyn Milani for the purposes of treatment, payment, and healthcare operations, or as otherwise required by law. I understand that I may request a written copy of Remedy Health's Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have read and understand the above statements regarding privacy. By signing here I agree to these policies.

_____	_____	_____
Patient Full Name	Patient Signature	Date
_____	_____	_____
Authorizing Party (Parent/Guardian) Full Name	Authorizing Party (Parent/Guardian) Signature	Date