

JAMES R. BRUNO, DMD, MD & C. COLEMAN BROWN, MD LLC
5454 Wisconsin Ave., Suite 1250, Chevy Chase, MD 20815

Acknowledgment of Receipt of General Notice – Form 1

I acknowledge that I was provided with a copy of the General Notice of my rights regarding release of my medical records.

Name of Patient (printed)

Date

Signature of Patient (or legally responsible individual)

General Authorization for Release of Medical Records – Form 2

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update notice if this occurs.

Name of Patient (printed)

Date

Signature of Patient (or legally responsible individual)

Date

Witness

Date

DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want Drs. Brown & Bruno, MD LLC (“Provider”) to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

The authorizations provided for above are subject to the following limitations or restrictions:

Patient Name (Printed)

Signature of Patient (or legally responsible individual) Date

Witness

Date