

Physician's Notice of Privacy Practices



I _____ have been provided with a copy of the Physician's Notice of Privacy Practices explaining how my private healthcare information is protected, used or disclosed.

I have reviewed this privacy notice and give my permission to the office of Roxanne J. Guy, M.D. to use and disclose my information in accordance with this notice.

Patient's Name: _____
(please print)

Patient's Signature: _____

Date: _____