FONTICIELLA MEDICAL CLINIC INC.

4000 LINWOOD DRIVE SUITE G

PARAGOULD AR 72450

I give permission to Fonticiella Medical Clinic, Inc. and any or all its providers to share private medical information about me which includes all names, address, and phone numbers.

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I understand:

- **State and Federal privacy laws protect my records.**
- **My records can be released only if I give my written permission or if the law requires it.**
- **I can refuse to sign this form, if I refuse, information will not be released to to the person named above, unless the law requires it.**
- **I can stop this consent to release information at any time by writing to Fonticiella Medical Clinic ,Inc. This written notice will not affect information the agency has already released.**
- **This consent will end one year from the date I signed it.**

Patient Name : ____________________________________ **SS#**_____________________________

Patient Signature ____

Date ____

Address ____

Telephone Number_________________________________ **or** _____________________________

Email Address ____

Witness: ____________________________________ **Date:** ________________________________