**Travis C. Holcombe, M.D., PC**

I have received and understand the HIPAA Notice of Privacy Practices Signature:

Print Name:

Patient name if minor:

Date:

I authorize the following person(s) to pick up, discuss or receive medical information pertaining to my healthcare **or** the healthcare of my minor child.

Name: Relationship:

Name: Relationship:

Name: Relationship:

Name: Relationship:

Patient Signature: Date:

Patient name if patient is minor: