Kelly E. Fordyce, M.D.

Acknowledgements and Authorizations:

- I have read and understand the HIPPA/Privacy Policy for Kelly E. Fordyce M.D., Inc. Initial:______
- I hereby assign my insurance benefits to be paid directly to the healthcare provider. Initial:______
- I authorize Kelly E. Fordyce M.D., Inc. to release my medical information required to process my claim. Initial:______
- I authorize Kelly E. Fordyce M.D., Inc. to obtain/have access to my medication history. Initial:______
- I authorize Kelly E. Fordyce M.D., to communicate with me via email and cellular device. Initial:______
- I authorize Kelly E. Fordyce M.D., Inc. to discuss my personal health information with the following individual(s): ____
  ____
- I authorize Kelly E. Fordyce M.D., Inc. to leave detailed information on a voicemail at the following number: ____

Patient Name: ____________________________________ Date: ________________

Signature of Patient or Legal Guardian: ______________________________________

Name of person signing if not patient: _______________________________________