170 Taylor Station Road, Suite 210, Columbus, OH 43213
Phone: (614) 626-4832 Fax: (614) 626-4834

Receipt of Patient Information

☐ I have received a copy of Your Private MD's **Patient-Physician Agreement AND Privacy Practice Statement** and will read at my leisure. I will contact the office with any questions regarding this policy after I have reviewed.

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Check One Below:

☐ I have a **Living Will/Advanced Directives** and/or a **Durable Power of Attorney** and will supply Your Private MD, LLC with a copy of it.
Name of Healthcare Power of Attorney: ____________________________
Relationship: ______________________

☐ I do not have a **Living Will/Advanced Directives** and/or a **Durable Power of Attorney** but would like information about them.

☐ I do not have a **Living Will/Advanced Directives** and/or a **Durable Power of Attorney** and am not interested in information at this time.

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I hereby give my consent for Gina Love-Walker, MD and staff of Your Private MD, LLC to discuss my protected health information with the following person(s):

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Signed: ____

Printed Name: __________________________ Date: ___________________________