MIND BODY INSTITUTE OF CHESTER COUNTY

423 EXTON COMMONS
EXTON, PA 19341

DUE TO THE NEW FEDERAL PATIENT CONFIDENTIALITY LAWS (HIPAA) OUR OFFICE WILL NEED YOUR PERMISSION TO DO THE FOLLOWING: CIRCLE ONE AND THEN INITIAL.

CONFIRM APPOINTMENTS	**YES ____**	**NO ____**
LEAVE MESSAGES WITH ANYONE OR ON RECORDER	**YES ____**	**NO ____**
LEAVE LAB RESULTS WITH ANYONE OR ON RECORDER	**YES ____**	**NO ____**

BY SIGNING THE ABOVE I FULLY UNDERSTAND THAT I AM GIVING M.ANJUM IRFAN, M.D, THE OFFICE OF DR. M. ANJUM IRFAN, PERMISSION TO DO THE ABOVE.

_____ **DATE**

_____ **PATIENT NAME**

_____ **GUARDIAN SIGN**

_____ **PATIENT SIGNATURE**

_____ **STAFF WITNESS**