Reliance/Privacy Practices Form

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Patient Name (PLEASE PRINT) Patient DOB

I hereby acknowledge that I have received or declined a copy of Rogue Valley Physicians, P.C.'s (RVP) **Notice of Privacy Practices (revised date 11/17/2017),** which includes information relating to our participation with Reliance eHealth Collaborative**.**

Initials

☐ **I AGREE** to have RVP release my records to Reliance

☐ **I DECLINE** to have RVP release my records to Reliance

_____ _____

Signature Date

_____

Signer's Name (if different than Patient)