

**I give permission to Dr. Olsen and the staff at Life's Bounty Medical Care to leave messages on my home and or cell phone voicemail.**

I have received a copy of HIPAA privacy laws and patients rights from Life's Bounty Medical Care.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature  
(Parent's Signature if patient  
if a minor)

\_\_\_\_\_  
Date

I make the following special request for confidential communications: **(The people who - in addition to myself may be given this confidential information are)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date