201 Montauk Highway · Suite 4
West Hampton Beach, NY 11978
631-878-1992

PATIENT SIGN-OFF FORM

I have read and understand the following documents:
(please check)

- ○ HIPAA
- ○ Release of Information
- ○ Signature on File
- ○ Patient Information & Office Policies

Name of Insured: Last ________________________________, First ____________________

Name of Patient: Last ________________________________, First ____________________

Patient's Relationship to Insured: ____

_______________________________________ ____________
Signature of Patient Date

_______________________________________ ____________
Printed Name Date