



DR. SABRINA HARRISON, M.D., P.C.

*I have read and understand the **NOTICE OF PRIVACY PRACTICES** as well as the **CONSENT FOR USE AND DISCLOSURE** of my medical records, and fully comply and agree to the terms that are stated in the disclosure.*

Patient Signature _____ Date _____

*I have read and understand the policy titled, **DETERMINING YOUR FINANCIAL RESPONSIBILITY**, and I fully comply and agree to the terms stated.*

Patient Signature _____ Date _____

*I have read and understand the policy stated for **PRESCRIPTION REFILLS, MESSAGES, APPOINTMENTS, AND LAB/TEST RESULTS**, and I fully comply and agree to the terms stated.*

Patient Signature _____ Date _____