PBS OB/GYN

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HIPAA ACKNOWLEDGMENT

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

I understand that under **The Health Insurance Portability And Accountability Act Of 1996 (HIPAA) I** have certain privacy rights regarding my protected health information. **I** have received this practice's notice of privacy practices written in plain language. The notice provides in detail the use and disclosures of my protected health information, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that you may use and disclose my medical records only for the following purposes: treatment, to obtain payment, health care operations and as required by law. Any other disclosures will be made only with my written authorization. understand that under **The Health Insurance Portability And Accountability Act Of 1996 (HIPAA) I** have certain privacy rights regarding my protected health information. **I** have received this practice's notice of privacy practices written in plain language. The notice provides in detail the use and disclosures of my protected health information, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that you may use and disclose my medical records only for the following purposes: treatment, to obtain payment, health care operations and as required by law.

Any other disclosures will be made only with my written authorization.

DO WE HAVE YOUR PERMISSION:	YES	NO
TO LEAVE YOUR TEST RESULTS ON YOUR ANSWERING MACHINE AT HOME?	☐	☐
TO LEAVE YOUR TEST RESULTS ON YOUR CELL PHONE ?	☐	☐

IF YOU WOULD LIKE TO GRANT ACCESS TO YOUR PROTECTED HEALTH INFORMATION TO A FAMILY MEMBER, SPOUSE, FRIEND, ETC., PLEASE FILL OUT THE FOLLOWING AND SIGN BELOW.

I _____ , HEREBY AUTHORIZE THE PERSON(S) LISTED
FIRST LAST NAME

BELOW ACCESS TO MY PROTECTED HEALTH INFORMATION (PHI), BY PHONE, IN PERSON, OR IN WRITING

_____ _____ _____ (____) _____–_____
FIRST LAST NAME RELATIONSHIP PHONE#

_____ _____ _____ (____) _____–_____
FIRST LAST NAME RELATIONSHIP PHONE#

_____ _____ _____ (____) _____–_____
FIRST LAST NAME RELATIONSHIP PHONE#

PLEASE UNDERSTAND THAT WE WILL NOT BE ABLE TO RELEASE ANY INFORMATION ABOUT YOUR MEDICAL CONDITION TO ANYONE NOT AUTHORIZED BY YOU. IT IS YOUR RESPONSIBILITY TO CHANGE / UPDATE THIS INFORMATION AS NECESSARY.

PATIENT NAME (PLEASE PRINT) _____ DOB: ____ / ____ / ____
FIRST LAST NAME

PATIENT SIGNATURE _____ DATE: ____ / ____ / ____