Privacy of our medical information is of utmost importance. A Health Insurance Portability and Accountability Act (HIPAA) office policy is in place. A copy may be requested in how your information is used, disclosed, and accessed. Please ask our staff for a copy of our Notice of Privacy Practices. With only a few exceptions defined by Federal Law, we cannot release any of your medical information to anyone, including your spouse and/or other family members, without your specific written consent.

SELECT ALL THAT APPLY

[yes/no] I give permission for Central Obstetrics & Gynecology to notify the listed persons of my blood work / test results and other personal health information.

Name / Relationship 1. ____

2.____

[yes/no] I give permission for Central Obstetrics & Gynecology to notify myself of normal lab results via email.

Email ______________________________@_________________

[yes/no] I give permission to Central Obstetrics and Gynecology to obtain lab results from referring physicians and hospitals pertinent to my care.

A request for release of information must be made in person. I understand the request cannot be made by phone, fax, or mailed.

X____________________________
(Patient Signature)

X____________________________
(Witness)

Notice of HIPPA Privacy Policy Acknowledgement of Receipt

X____________________________
(Patient Signature)

X____________________________
(Witness)

Print Name:_________________________________ Date:___________________

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