Women First OB/GYN P.C.

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDEMENT

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practice Acknowledgement for Women First OB/GYN P.C. The notice describes the types and uses of disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. I understand that this organization may change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

RELEASE OF INFORMATION

As a patient of Women First your privacy is very important to us. There may be times, however, when you are not personally available to speak with any office representative. In these cases, we will need instruction on whom to contact and/or where it is acceptable to leave any personal information, such as results of blood work, pap smears, biopsies, or any other office procedure that were performed.

Please realize that all blood and culture results take one week. Pap smear results take two weeks. There is an extra charge for any stat orders. You are welcome to go directly to a lab center for all your blood draws, if you prefer.

Please indicate below whether you wish to have normal results left on voicemail:

□ NO □YES phone number:_____

Please indicate whether this is: □Home □Work □Cell

□ Designated Individual's Phone number:_____

Do you also consent to leave a detailed message at the above number for abnormal values?

□ NO □ YES

In the event voicemail is not available, please provide the name(s) of any person(s) with whom we are permitted to leave results.

_____

Name Relationship Password

_____

Name Relationship Password

Patient or legal guardian:

Print Name:_____ Date:_____

Patient Signature:_____ _____

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