

# Gynecology and Obstetrics of DeKalb, P.C.

## Patient Notice

(Request For Limitations and Restrictions of PHI)

**HIPAA** (Health Insurance Portability & Accountability Act of 1966; a federal law) requires healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your **Protected Health Information (PHI)**.

With my consent, Gynecology and Obstetrics of DeKalb, P.C. may use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operations (TPO). Please refer to Gynecology and Obstetrics of DeKalb, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. **Please Note: The practice is not required to agree to your request. Please see Notice of Privacy Practices for more information regarding such requests.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment  
City State Zip

I authorize Gynecology and Obstetrics of DeKalb, P.C. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

### ***Please check Yes or No and Write Telephone Number(s)***

Best daytime contact telephone	Number: _____		
Home telephone (H)	Yes	No	Number: _____
Ans. machine (home) (HAM)	Yes	No	
Work telephone (W)	Yes	No	Number: _____
Voice Mail (work) (VM)	Yes	No	
Cell phone (C)	Yes	No	Number: _____
Pager (P)	Yes	No	Number: _____
Email (E)	Yes	No	Address: _____

**We will try to honor your above request. However, if you DO NOT give us a telephone number, we will not be able to contact you with your lab results. Therefore, you will have to schedule an office visit appointment to discuss your results, whether normal or abnormal.**

Please list names of people **we can discuss** your medical care with:

Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_

Other (Name): \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Parent/Legal Guardian