GYNECOLOGY & OBSTETRICS OF DEKALB

PATIENT NOTICE

(Request for Limitations and Restrictions of PHI)

HIPAA (Health Insurance Portability & Accountability Act of 1996, 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 out treatment, payment and healthcare operations (TPO). Please refer to Gynecology & 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 _____

_____

I authorize Gynecology & 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.

First Best Contact Number: _____

Please Circle One: HOME WORK CELL OTHER: _____

(Please be advised you will receive appointment reminders and a possible message to contact our office. This will NOT include any results.)

Second Best Contact Number: _____

Please Circle One: HOME WORK CELL OTHER: _____

(Please be advised you will receive a possible message to contact our office. This will NOT include any results.)

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. You may be asked 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:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____