GYNECOLOGY & OBSTETRICS ASSOCIATES OF TALLAHASSEE
CARING FOR GENERATIONS OF WOMEN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information (including the results of any DNA analysis). I understand that this information can and will be disclosed and used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly and indirectly
- Share my treatment, condition and dates with all my healthcare providers involved in my treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians' certifications
- Act in furtherance of the other purposes listed in the Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information or obtained a hard copy at my request. I understand that I may obtain a current copy, at any time, of the Notice of Privacy Practices from Gynecology and Obstetrics Associates of Tallahassee ("the Practice").

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize the Practice to disclose my personal health information by the following means of communication:

Home number: _____ ☐ Include a detailed message via voicemail ☐ Do not include

Home number: _____ ☐ Include a detailed message via voicemail ☐ Do not include

Mobile Number:_____ ☐ Include a detailed message via voicemail ☐ Do not include

Mobile Number:_____ ☐ Include a detailed message via voicemail ☐ Do not include

I authorize sharing my protected health information with the following individuals and I understand I am responsible for notifying the Practice of any changes: (Please print legibly)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

By signing this document, I (the undersigned) understand and affirmatively state it is my intentional decision to consent to the Practice using and disclosing my protected health information to third parties as set forth above and in the Notice of Privacy Practices. I understand I may revoke this authorization in writing by contacting the Practice.

Patient Name: _____ Date: _____

Signature: _____

Name of Legal Guardian/Authorized Representative: _____ Date: _____

Signature: _____ Relationship: _____