Complete Healthcare for Women of Wellington, LLC
Gynecology

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

Upon request, I can receive and read your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I have the right to review the notice prior to signing this consent.

RELEASE OF MEDICAL INFORMATION

It is important for us to honor the confidentiality between patient and physician.
Please check your preference below.

_____ You may discuss my medical information ***ONLY*** with me.
Initial

OR

_____ I give permission to discuss my medical information with the following people:
Initial

1) _____ Relationship _____
2) _____ Relationship _____
3) _____ Relationship _____

You may reach me at the following telephone number: _____ and/or leave a message with the person answering or via an answering machine (detailed results will not be disclosed).

☐ Consent to receive text message via patient portal _____ (cell phone)

Patient Name (Please Print): _____ DOB: _____

Patient Signature: _____

Date: _____