GALLATIN WOMEN'S CENTER, PC

NOTICE OF PRIVACY PRACTICES ACKNWOLEDGMENT

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

- Conduct, plan and direct my treatment and follow-up among all healthcare providers who may be involved in my 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 Practices* containing a complete description of the uses and disclosures of my health information. I understand Gallatin Women's Center has the right to change its *Notice of Privacy Practices* and that I may contact them to obtain a current copy.

I understand that I may request in writing that Gallatin Women's Center restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Gallatin Women's Center is not required to agree to my request bit if you do agree then they will be bound to abide by such restrictions.

Signature of Patient or Guarantor if patient is under 18 years of age.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

I, _____ (patient name) give permission for Gallatin Women's Center to discuss my medical care with the following:

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

In addition, I give permission for Gallatin Women's Center to call me or leave a message for the purpose of notification of appointment reminders or laboratory results at the following number.

_____ _____
Home Phone Cell Phone

_____ _____
Emergency Contact Name Phone

_____ _____
Signature Date

GALLATIN WOMEN'S CENTER, PC

Patient Name_____ Date of Birth_____

PERMISSION TO RELEASE PRESCRIPTIONS TO ANOTHER INDIVIDUAL

I give permission for the following to pick up written prescriptions and/or sample medication and/or prescribed medication on my behalf.

_____ _____
Name Phone

_____ _____
Name Phone

_____ _____
Name Phone

_____ _____
Patient Signature Date

PERMISSION TO RELEASE MEDICAL INFORMATION TO ANOTHER INDIVIDUAL

Please list the name(s) of any individual(s) you would like to allow to pick-up or receive medical information on your behalf, including but not limited to, test results (lab & imaging), return to work/school notes, confirmation of pregnancy and appointment reminders.

_____ _____
Name Phone

_____ _____
Name Phone

_____ _____
Name Phone

☐ I do not wish for any individual(s) to receive medical information on my behalf.

I give permission for Gallatin Women's Center to leave a message regarding medical information such as appointment information, reminders, lab & imaging results or returned message from a nurse at the following numbers:

_____ _____ _____
Home Phone Cell Phone Work Phone

☐ I do not wish for my information to be left on a voice mail/answering machine.

_____ _____
Patient Signature Date