MID-ATLANTIC OBGYN
physicians & midwives

HIPAA

Section I: Patient Acknowledgment & Consent Form (This section is a summary of the government mandated HIPAA)
Mid-Atlantic OB-GYN may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change terms described as determined by the government. Should this happen we will display the new policy and effective date at our office locations. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

Section II: Consent for use and Disclosure of Information by Mid-Atlantic OB-GYN
By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent. "I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Mid-Atlantic OB-GYN for any services furnished to me by my physician, I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements."

Patient's Signature _____Date _____

Section III (Optional): Name Personal Representative(s), Family, or Other Entities whom you want to grant Authorized Access to YOUR Protected Health Information Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations:

_____
Name of Authorized Person Relationship Phone #

_____
Name of Authorized Person Relationship Phone #

Section IV: Authorization for use of Answering Machine, Voice Mail, AND/OR Email Address
Mid-Atlantic OB-GYN is sometimes unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Information that we may possibly disclose on your home, work, cell phone, or email address would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) I agree to allow Mid-Atlantic OB-GYN to leave messages that include Protected Healthcare

Information on the following: Please mark the applicable communication devices:

□ Home □ Work □ Cell □ Email Address

_____ (Initial) No, I do not agree to allow Mid-Atlantic OB-GYN to leave messages that include Protected

Healthcare Information on my home, work, cell phone, or email address.

Patient's Signature _____ Date _____