Privacy Practices Acknowledgement

I have received and/or reviewed the Notice of Privacy Practices; I understand a copy will be provided to me upon my request.

I wish to be contacted in the following manner (please check all that apply).

☐ Yes ☐ No **Cell phone** _____

OK to leave message with detailed information ☐ Yes ☐ No

Leave message with call back number ONLY ☐ Yes ☐ No

☐ Yes ☐ No **Home phone** _____

OK to leave message with detailed information ☐ Yes ☐ No

Leave message with call back number ONLY ☐ Yes ☐ No

☐ Yes ☐ No **Work phone** _____

OK to leave message with detailed information

Leave message with call back number ONLY

☐ Yes ☐ No **Written communication (test results/billing information)**

OK to mail to my home address_____

OK to mail to my work address _____

OK to fax to this number _____

☐ Yes ☐ No **Electronic communication (email results/billing information)**

OK to email me at my personal email address _____

Signature: _____ Date: _____

Patient Record of Disclosures

I authorize CR OB Gyn Specialists to share my protected health information (PHI) with the individual(s) listed below. This would include any medical/chart information and/or any financial/billing information.

Name _____ Relationship _____

Patient Name: _____ Date of birth: _____

Signature: _____ Date: _____