Damien Fertility Partners Regional Women's Health Group, LLC

HIPAA

Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

opportunity to review this Noti	ce of our Privacy Practices:			
Print Name:		Date of Birth:		
Signature:		Date:		
II. Authorization for	or use or Disclosure of He	ealth Information		
Patient Contact Information	on			
Home #:	Cell #:	Work #:	Ext: _	
I authorize messages with medi	cal information to be left on voicemai	l at (check all that apply): \Box	Home □ Cell □ Wo	ork
I authorize Brief message detail	s: □ Home □ Cell □ Work I au	ıthorize Extended message d	etails: 🗆 Home 🗆 Cell 🗈	∃Work
	mmunications be sent to my email add			
	y and Treatment Information			
•	dual(s) to receive information pertaining	ng to any medical history and	treatment received:	
_	Relationship:			
Name:	Relationship:	DOB:	Ph:	
Restrictions/Instructions:				
Release of Billing Informa	tion			
_	dual(s) to receive information pertaining		-	
	Relationship:			
Name:	Relationship:	DOB:	Ph:	
Restrictions/Instructions:				
Patient Acknowledgement				
In accordance with the Privacy that:	Rule of the Health Insurance Portab	pility and Accountability Act	(HIPAA) of 1996, I und	lerstand
1. I may revoke this authorication for	ization at any time, except to the exte disclosure. My revocation must be in exation will be effective once receive	writing, signed by me or on	my behalf, and delivered	to your
2. A copy of this authorizati	on may be used with the same effective	veness as the original.		
This authorization replaces any information.	prior written authorization I have m	ade regarding the use, releas	se, and disclosure of my	medical
Print Name:		Date	2:	
			:	
Additional Authorizations				
Emergency Contact:	Relation	nship:	Phone:	
I request a female escort to be r	oresent during my examination? Ye	s 🗆 No 🗀 Other		