St. Bernards OB-GYN ASSOCIATES
The Heart of Great Medicine

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the clinic's Notice of Privacy Practices.
(Patient Name - Please Print)

_____ _____
Signature of Patient or Legal Guardian Date

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices. **Yes** **No** (Please circle)

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For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgement refused:

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____

Patients Date of Birth: _____/_____/_____

Patient's Chart Number: _____

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THIRD PARTY ACCESS FORM

Patient Name _____ Date of Birth _____/_____/_____

Patient Address _____

Chart # _____ Social Security # _____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING:

SPOUSE: Name:_____ Phone: _____

CHILDREN: Name:_____ Phone: _____

FAMILY MEMBER: Name:_____ Phone: _____

EMPLOYER: Name:_____ Phone: _____

If any of these individuals contact us, they will be asked to provide your social security number. Please make sure they know this information. Anyone who is not named above or who cannot provide your social security number will be denied access to your Protected Health Information.

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.
- I understand I may revoke this authorization at any time by signing the revocation section of this form and returning it to the address above. I further understand any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
- I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will not depend in any way on whether or not I sign this authorization.
- I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand the clinic named above will not receive compensation for the uses and disclosures I have authorized.

Note: After the initial completion of this form, any additions or deletions must be given to the healthcare provider in writing.

Name (Please Print):_____

Signature_____ Date: _____

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REVOCATION SECTION

I hereby revoke this authorization: _____ _____
Signature Date

Revocation received by the clinic: _____ _____
Signature Date