Patient Name: _____ Chart#: _____
First Middle Initial Last

Patient's Date of Birth: _____ Patient's Social Security # or Driver License #_____

HIPPA Privacy Notice Acknowledgement

I have read the Notice of Privacy Practices for Columbus ObGyn Specialty Center. I understand that I may ask questions if I do not understand any part of the notice. I may also request a copy of the notice for my personal records.

_____ _____
Signature of Patient **Date**

Authorization for Disclosure of Private Health Information to Family/Friend

I hereby authorize Gregory W. Childrey, M.D., Clay B. Hudson, M.D., and their staff to discuss my private health information, to include the results of my medical tests such as pap smears, biopsies, exam findings, etc., and the need for further treatment based on the findings of such tests, with the following person(s):

Name	**Relationship**
_____	_____
_____	_____
_____	_____

I understand that because the person(s) receiving this information is/are not a health plan(s) or health care provider(s) covered by federal privacy regulations, the information may be disclosed by the recipient(s) and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Columbus ObGyn Specialty Center in writing and that if I choose to do so, my request to revoke will not affect any actions by Columbus ObGyn Specialty Center before receiving my revocation.

_____ _____
Signature of Patient **Date**

Authorization Denied to Disclose Private Health Information to Family/Friend

I am not a minor, and I do NOT want my private health information to be disclosed to any family member or friend. I understand that my refusal will not affect my treatment, payment, or eligibility for benefits.

_____ _____
Signature of Patient **Date**