North Texas Perinatal Associates

"Committed to turning high-risk pregnancies into low-risk deliveries."

Acknowledgement of Receipt of Notice Privacy Practices
Authorization to Release Information to Others
Advance Directive / Living Will

Acknowledgement of Receipt of Notice of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of discl osures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the office to obta in the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations, and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I have read and acknowledged the above information. (Please initial.)__________

Authorization to Release Information to Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information out without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

No, you may not disclose my information to anyone but me. _________
Yes, you may disclose my information to the following people listed below. _________

Name: ______________________ Relationship to Patient: ______________ Date: __________

Name: ______________________ Relationship to Patient: ______________ Date: __________

Please provide phone numbers at which we can contact you or leave a message regarding lab results, appointment reminders, changes to scheduled appointments and billing information.

Home Phone: ______________________ Work Phone: ______________ Cell Phone: __________

Advance Directive / Living Will

Do you have an advance directive or living will? YES _______ NO _______

If no, are you interested in receiving information pertaining to one? YES _______ NO________

____

____
Patient Name (Please print.)

____
Relationship to Patient (Please print.)

____
Date of Signature

____
Signature of Patient or Guardian