ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AMENDED 09/23/2013

I, ____, have been offered to review a copy of this office's amended Notice of Privacy Practices.

____
Print patient's name

____
Signature

____
Date

I give my consent to speak with the following person(s) concerning the care and treatment that I may be receiving at Sarasota OB/GYN Associates. This information includes, but is not limited to telephone or in-person conversations and inquires concerning my visits, outcome, treatment, and billing.

____
Name Relationship Phone

____
Name Relationship Phone

____
Name Relationship Phone

I consent to having my results left on my voicemail on my home phone: Yes or No (circle)
I consent to having my results left on my voicemail on my cell phone: Yes or No (circle)

By initialing, I acknowledge that my paper chart will be shredded and all of my medical records will be kept electronically. I understand Sarasota OB/GYN Associates is using the services of Sarasota Document Shredding, in accordance with all HIPAA regulations.
INITIAL: _________

For Office Staff Use Only

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because the patient refused to sign.

____
Office Staff Name Signature Date