Arbor Obstetrics and Gynecology

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that the Arbor Ob Gyn Privacy Notice (Revision Date, July 12, 2016) has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also displayed in the waiting room and on our website at www.arborobgyn.com. Arbor reserves the right to revise its notice of Privacy Practices at any time. A revised copy may be obtained by forwarding a written request to our office at 4360 Chamblee Dunwoody Rd., Suite 370, Atlanta, GA 30341

_____ _____ _____

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Patient's Date of Birth

_____ _____

Personal Representative's Relation to Patient | Date

Documentation of Good Faith Effort

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

_____ Patient refused to sign the Privacy Notice Acknowledgement
_____ Patient was unable to sign because: _____
_____ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical
_____ Other reason, describe: _____

_____ _____ _____

Employee's Name Printed | Employee's Signature | Date

Authorization to Disclose Protected Health Information to Carry out Treatment, Payment and Healthcare Operations (TPO)

I authorize Arbor Ob Gyn to use and disclose my Protected Health Information as needed to be able to carry out treatments, payment and healthcare operations. This includes actions such as appointment reminders, sending patient statements and releasing information to health care plans for the processing of claims.

_____ _____ _____

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Date

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Authorization to Release Protected Health Information (PHI) to Specific Persons or Entities

I hereby authorized Arbor Ob Gyn to release my protected health information to the following: (Please check and provide the persons or specific entities to which your protected health information may be given.)

_____ Family members or friends: (please give names and contact information)

Name:_____ Relationship:_____ Phone number:_____

Name:_____ Relationship:_____ Phone number:_____

_____ School or Employer: (list names of school/employer)

_____

_____ Other: _____

_____ _____ _____

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Date

Contact Preferences and Authorization to Leave Medical Information (PHI).

*** Whenever possible, Arbor Ob Gyn will use your password protected patient portal for communicating with you. This is our primary method of communicating with patients so please notify us immediately if you are not able to access the portal and need assistance resetting your password. In the event that we need to contact you via another means please indicate your preferences below.

I authorize Arbor Ob Gyn to leave medical information (PHI) pertaining to my care by the following methods:

Home telephone (answering machine)	Yes	No	Number:_____
Work telephone	Yes	No	Number:_____
Cell Phone	Yes	No	Number:_____
Email	Yes	No	Address:_____

_____ _____ _____

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Date

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Other Authorizations:

Authorization to Access Medication History:	Yes	/	No
Authorization to share vaccination information between Arbor & the Georgia Immunization Registry (GRITS):	Yes	/	No
Authorization to chart share with other providers who use Athena Clinical Electronic Records or with providers who participate with CommonWell Health Alliance:	Yes	/	No

_____ _____ _____

Patient or Personal Representative's Name Printed | Patient or Personal Representative's Signature | Date

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Other:

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_____

_____

_____

You may revoke any or all of your authorizations in writing, except to the extent that the practice has already made disclosures based on your prior consent. Written request to revoke authorization should be submitted to Arbor Ob Gyn, 4360 Chamblee Dunwoody Rd., Atlanta, GA 30341