

Center for Women's Health at Avon
Meridian Obstetrics and Gynecology Associates
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Acknowledgement of Receipt of Notice of HIPAA Privacy

I, _____, acknowledge that I have been provided with a copy of the Notice of HIPAA Privacy.

Date: _____

Patient Name: _____

Date of Birth: _____

Signature of Patient/Parent/ Guardian: _____

Medical Release (including minors)

I hereby authorize The Center for Women's Health to furnish information and/or discuss information contained in my medical record, including appointment information, with the following person or persons: (Include nurse case managers, if applicable.)

Please indicate below all family members and/or other person(s) the practice may discuss your medical condition with. If the person is not listed below, we cannot disclose any information under any circumstance.

(Name)

(Relationship to patient)

(Name)

(Relationship to patient)

(Name)

(Relationship to patient)

(Name)

(Relationship to patient)

This notice is effective as of April 14, 2003.