



The **Notice of Privacy Policies and Practices** tells you, the patient, about the ways we may use and disclose your medical information. It also explains your rights and our obligations regarding the use and disclosure of your medical records. This **Notice** applies to all parties associated with Park Central OB/GYN Associates. You are also provided the right to request confidential communications or that a communication of your information be made by alternative means, such as sending correspondence to your office instead of your home.

I wish to be contacted in the following manner (check all that apply)

- Home Telephone _____ Written communication
 O.K. to leave message with detailed information O.K. to mail to my home
 Leave message with call-back number only O.K. to mail to my work
- Work Telephone _____ Other _____
 O.K to leave message with detailed information _____
 Leave message with call-back number only _____

Patient Signature Date

Print Name Date of Birth

By my signature below, I acknowledge that I have received the Practice's **Notice of Privacy Practices** describing the **Health Insurance Portability and Accountability Act of 1996 ("HIPAA")**.

Name of Patient: _____
Patient Signature: _____ Date: _____

I hereby give my permission to discuss my medical care with the following persons:

_____ Initial _____

I hereby request the following restrictions on the use of my information:

_____ Initial _____