HIGH RISK OBSTETRICAL CONSULTANTS, PLLC
NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Please check yes or no to the questions below related to your New Patient Information Sheet.

I may be contacted on the phone numbers I provided: Yes ☐ No ☐

Additional notes: _____

I may be contacted on my cell phone via SMS/text message: Yes ☐ No ☐

Voicemail messages may be left on the following numbers listed above (circle all that apply):

Cell Home Work Other

I authorize the following people to be made aware of emergencies, my test results, appointment times, medical information and patient account status on the phone number(s) I provided and/or on the numbers listed below.

Name	Relationship to Patient	Contact Number

I may be contacted via mail at my home address: Yes ☐ No ☐

I may be contacted via the email: Yes ☐ No ☐

When discussed with staff, photos may be emailed or mailed: Yes ☐ No ☐

I understand that if someone inquires about any of the information listed above and is NOT on this consent, information will NOT BE RELEASED. This request will remain in effect until revoked by me in writing.

_____ _____
Patient Name Date

_____ _____
Patient Signature Witness