

MAGNOLIA OBSTETRICS AND GYNECOLOGY, PLLC

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Patient Initials _____	<p style="text-align: center;">RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM</p> <p>I, _____ acknowledge confirmation and receipt of the office privacy practices for the office of Magnolia Obstetrics and Gynecology, PLLC.</p>
_____	<p style="text-align: center;">PRIVACY CONSENT</p> <p>I authorize the Office of Magnolia OB/GYN to release the following information to:</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Please include your full name and relationship. (i.e. Joe Smith- spouse, or Jane Smith- mother, ect...)</p> <p>_____ Medical Information Only (including but not limited to all test results, office/clinical notes, medications, and correspondence)</p> <p>_____ Financial Information Only</p> <p>_____ All Medical and Financial Information</p>
_____	<p style="text-align: center;">TEST RESULTS</p> <p>Do you want your results by phone call? YES or NO</p> <p>If <u>YES</u>, what number can we leave a <u>detailed voicemail</u> with your results on?</p> <p style="text-align: center;">(#) _____</p> <p>If NO, we will mail a letter to the address on file in our system. Please make sure you have given us your current mailing address before you are seen by the physician.</p>
_____	<p>I also understand that it is my responsibility to update the office with any changes in personal, medical, financial, or contact information.</p>

By signing below, I confirm I have read, understand, and have given correct information to the best of my ability.

PATIENT NAME PRINTED

DATE

SIGNATURE OF PATIENT