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NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date**: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Walnut Hill OB/GYN may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Walnut Hill OB/GYN has a detailed document called the "NOTICE OF PRIVACY PRACTICES." It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing the agreement. I fi ask, Walnut Hill OB/GYN will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Walnut Hill OB/GYN to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Walnut Hill OB/GYN has taken action relying on this consent.

SIGNATURE: _____ **DATE**: _____
(Patient or Legal Custodian/Authorized Representative)

RELATIONSHIP TO PATIENT if signed by another party: _____
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our "Notice" at any time by contacting: Walnut Hill OB/GYN Associates @ 214-363-7801