Haven Ob/Gyn

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that the Haven Ob Gyn Privacy Notice (Revision Date, July 12, 2016) has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also available in the waiting room and on our website at www.Havenob.com. Haven Ob Gyn reserves the right to revise its notice of Privacy Practices at any time. A revised copy may be obtained by forwarding a written request to our office at 4360 Chamblee Dunwoody Rd., Suite 370, Atlanta, GA 30341

Documentation of Good Faith Effort
The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

________ Patient refused to sign the Privacy Notice Acknowledgement
________Patient was unable to sign because: ____
________ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical
________ Other reason, describe: ____

________________________ ________________________ ____________________
Employee's Name Printed Employee's Signature Date

Authorization to Disclose Protected Health Information to Carry out Treatment, Payment and Healthcare Operations (TPO)

I authorize Haven Ob Gyn to use and disclose my Protected Health Information as needed to be able to carry out treatments, payment and healthcare operations. This includes actions such as appointment reminders, sending patient statements and releasing information to health care plans for the processing of claims.

________________________________ ________________________________ ______________
Patient or Personal Representative's Name Printed Patient or Personal Representative's Signature Date

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Contact Preferences and Authorization to Leave Medical Information (Protected Health Information "PHI").

*** Whenever possible, Haven Ob Gyn will use your password protected patient portal for communicating with you. This is our primary method of communicating with patients so please notify us immediately if you are not able to access the portal and need assistance . In the event that we need to contact you via another means please indicate your preferences below. Please check the box in front of your preferred contact number.
I authorize Haven Ob Gyn to leave medical information (PHI) pertaining to my care by the following methods:

☐ Home telephone: (______)______-_________ ☐ OK to call, but do not leave PHI ☐ Ok to leave PHI ☐ Do not call

☐ Work telephone: (______)______-_________ ☐ OK to call, but do not leave PHI ☐ Ok to leave PHI ☐ Do not call

☐ Cell Phone: (______)______-_________ ☐ OK to call, but do not leave PHI ☐ Ok to leave PHI ☐ Do not call

Email Address:_________________________ OK to use for communications that include PHI ☐ Yes ☐ No

Please note that we may contact you and leave information that does not include PHI at the above numbers or email unless you indicate "do not call". Examples of calls that do not include PHI include appointment reminders, messages that we need you to call us back regarding results, and messages that we have sent a requested prescription to your pharmacy. These messages will not include actual test results or names of medications unless you have indicated that it is Ok to leave PHI

________________________________ ________________________________ ______________
Patient or Personal Representative's Name Printed Patient or Personal Representative's Signature Date

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Other Authorizations:

Authorization to Access Medication History: Yes / No

Authorization to share vaccination information between Haven & the Georgia Immunization Registry (GRITS): Yes / No

Authorization to chart share with other providers who use Athena Clinical Electronic Records or with providers who participate with CommonWell Health Alliance: Yes / No

______________________________	______________________________	________________
Patient or Personal Representative's Name Printed	Patient or Personal Representative's Signature	Date

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Authorization to Release Protected Health Information (PHI) to Specific Persons or Entities

I hereby authorize Haven Ob Gyn to release my protected health information to the following persons or entities: (Please list the person you want us to use as your emergency contact first.)

Name:_________________________ Relationship:_____________________ Phone number:________________

I authorize Haven Ob Gyn to disclose:
- □ Any and all of my medical information with the above named person(s)
- □ Only information that my provider feels is urgent or in an emergency situation.

Name:_________________________ Relationship:_____________________ Phone number:________________

I authorize Haven Ob Gyn to disclose:
- □ Any and all of my medical information with the above named person(s)
- □ Only information that my provider feels is urgent or in an emergency situation.

Name:_________________________ Relationship:_____________________ Phone number:________________

I authorize Haven Ob Gyn to disclose:
- □ Any and all of my medical information with the above named person(s)
- □ Only information that my provider feels is urgent or in an emergency situation.

______________________________	______________________________	________________
Patient or Personal Representative's Name Printed	Patient or Personal Representative's Signature	Date

You may revoke any or all of your authorizations in writing, except to the extent that the practice has already made disclosures based on your prior consent. Written request to revoke authorization should be submitted to Haven Ob Gyn, 4360 Chamblee Dunwoody Rd., Atlanta, GA 30341