



Haven Ob/Gyn, LLC

Brad Moore MD

Bryan Jewell MD

Leah Pombo WHNP

4360 Chamblee Dunwoody Road
Suite 370
Atlanta, GA 30341

(P) 770.393.1988
(F) 770.399.5726
www.HavenOb.com

I acknowledge that the Haven Ob/Gyn Privacy Notice (Revision Date, April 25, 2020) 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

Patient or Personal Representative's Name Printed

Patient or Personal Representative's Signature

Date

Personal Representative's Relation to Patient

Date

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

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

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

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