Women's Health & Surgical Services

John Gordon D.O.

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Patient Name: _____ Date of Birth: _____

Patient Information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your case. Patient hereby waives her confidentiality rights should collection action become necessary. You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office. However, we are not obligated to alter internal policies to conform to your requests.

My protected health information can be released to the following people:

Name: _____ Relationship: _____ Phone: _____

Address: _____

Name: _____ Relationship: _____ Phone: _____

Address: _____

Name: _____ Relationship: _____ Phone: _____

Address: _____

With this consent, I give Women's Health & Surgical Services permission to call my home or alternative location provided in patient information form and leave detailed message on voicemail or in person to someone listed above in reference to any items that assist the practice in carting out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care such as lab and tests results.

_____ _____

Patient Signature (or parent, guardian, or legal representative) Date