



JOHNSON COUNTY OB/GYN CHRTD
RECEIPT: NOTICE OF PRIVACY PRACTICES

I understand that in compliance with HIPAA guidelines, Johnson County OB/GYN will disclose my personal medical information for treatment, payment, and operational purposes only. Additionally, I allow that my medical information may be released to the individuals I have designated below.

I grant permission to disclose my medical information to the following individuals:

_____	_____	_____	YES / NO
Name, please print	Relationship	Phone Number	OK to leave voicemail? Circle One
_____	_____	_____	YES / NO
Name, please print	Relationship	Phone Number	OK to leave voicemail? Circle One
_____	_____	_____	YES / NO
Name, please print	Relationship	Phone Number	OK to leave voicemail? Circle One

I acknowledge that I have been provided with a copy of the Johnson County OB/GYN Notice of Privacy Practices. I also acknowledge that the information I have provided may be updated *at my request* AND with the completion of a new *RECEIPT: NOTICE OF PRIVACY PRACTICES* document.

_____	_____	YES / NO
Patient Name, please print	Phone #1	OK to leave voicemail? Circle One
_____	_____	YES / NO
	Phone #2	OK to leave voicemail? Circle One
_____	_____	
Patient Signature	Date	