

**NORTH SCOTTSDALE WOMEN'S HEALTH
HIPAA PRIVACY ACKNOWLEDGEMENT**

I _____ (pt's name) have received the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize North Scottsdale Women's Health to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to North Scottsdale Women's Health upon request.

PERSONAL REPRESENTATIVES (family members, other health care professionals, attorneys, etc): I hereby authorize North Scottsdale Women's Health and its Employees permission to discuss, send and/or receive medical information to/with the following individuals, including leaving a message with them to speak with you:

Name /Relationship to Patient _____

Name /Relationship to Patient _____

Name /Relationship to Patient _____

CONSENT FOR MESSAGES:

It is ok to leave a message on my cell voice mail # _____

RE: Y N Appt times Y N Test results Y N Billing/Insurance

It is ok to leave a message on my home voice mail # _____

RE: Y N Appt times Y N Test results Y N Billing/Insurance

PLEASE do not leave a message on my home or cell phone voice mail, I will contact the office for all test results.

Y N When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential.

Name _____ Date _____