PATIENT NOTICE
(Request for Limitations and Restrictions of PHI)

HIPAA (Health Insurance Portability & Accountability Act of 1996; a federal law) requires healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your Protected Health Information (PHI).

With my consent, Gynecology and Obstetrics of DeKalb, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Gynecology & Obstetrics of DeKalb, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures. Please note: The practice is not required to agree to your request. Please see Notice of Privacy Practices for more information regarding such requests.

Patient Name _____ Date of Birth: _____
Address _____

I authorize Gynecology & Obstetrics of DeKalb, PC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Best daytime contact telephone			Number: _____
Home telephone	Yes	No	Number: _____
Answering machine (home)	Yes	No	
Work telephone	Yes	No	Number: _____
Voicemail (work)	Yes	No	
Cell phone	Yes	No	Number: _____
Pager	Yes	No	Number: _____
Email	Yes	No	Address: _____

We will try to honor your above request. However, if you DO NOT give us a telephone number, we will not be able to contact you with your lab results. Therefore, you will have to schedule an office visit appointment to discuss your results, whether normal or abnormal.

Please list names of people we can discuss your medical care with:
Spouse: _____ Parent: _____
Other: _____ Relationship: _____
Signature: _____ Date: _____