GATEWAY OBSTETRICS & GYNECOLOGY

1110 Cottonwood Lane, Suite 200

Irving, Texas 75038

HIPAA PRIVACY ACT INFORMATION

Please check the appropriate boxes below for release of medical information:

Release information **only to myself**: Yes No

Release information to additional person(s): Yes No

The following person(s) may receive consultation concerning specified medical information:

Name _____ Phone# _____ Relation: _____

Release specific information (state **All** or **Specify**): _____

Name _____ Phone# _____ Relation: _____

Release specific information (state **All** or **Specify**): _____

Name _____ Phone# _____ Relation: _____

Release specific information (state **All** or **Specify**): _____

Permission to leave medical information on your answering machine or voicemail: Yes No

Phone Number for messages: _____

Patient Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Gateway Obstetrics & Gynecology reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices.

Name (print): _____

Signature: _____ **Date:** _____

Signature of Patient Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

(Required if patient is a minor or adult who is unable to sign this form)

Signature expires one year from date of this form.