Instructions:
Please complete this form by typing in the information, then print it, sign it, and bring it to our office.

Armando L. Rojas, MD
Thomas R. Anthony, MD
Carlos A. Rodriguez, MD
Oscar Osorio, MD
Regina Epple, ARNP
Maryann Noval, ARNP

HIPAA RESTRICTIONS

Date: Patient Name: Date of Birth:

Name of person(s) whom may speak with our office staff regarding your treatment, statements and health care operations.	This persons relationship to you.

Please read the questions below and click the box to select your answer.

Is it okay for Genesis Women's Center staff to leave a detailed message at your home? Yes ☐ No ☐

Is it okay for Genesis Women's Center staff to leave a detailed message on a cell phone you provide? Yes ☐ No ☐

Is it okay for Genesis Women's Center staff to leave a message at your work to call our office? Yes ☐ No ☐

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

*Obtain payment from third-party payers

*Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy policy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name Relationship to Patient

Signature ______________________________ Date______________________

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ____________ Initials:____________ Reason: ______________________________

____

800 Medical Court East, Inverness, FL 34452
Phone 352-726-7667 * Fax 352-726-8193

6254 W. Corporate Oaks Dr., Crystal River, FL 34429
Phone 352-795-3232 * Fax 352-795-3350