Austin ObGyn Associates

Privacy Policy

I acknowledge that Austin ObGyn Associates has provided me with access to a written copy of the Notice of Privacy Policy. I also acknowledge that I have been offered the opportunity to read the Notice of Privacy Policy and ask questions.

I understand that in order to disclose my protected health information Austin ObGyn Associates must have my written consent. Therefore, I authorize Austin ObGyn Associates to disclose my protected health information as described on this form.

Please indicate the phone number you wish for us to use to contact you with confidential information and if we may leave a voicemail containing confidential information.
_____ cell/home/work (please circle)

☐ I do not wish for any confidential information to be left on voicemail.
(please check if this is the case)

Please list below the names of people to whom we may give your confidential information:

_____

Name/Relationship Phone Number

_____

Name/Relationship Phone Number

Patient Name:_____

Date of birth:_____ Social Security Number:_____

Patient or Patient's Guardian Signature:_____

Relationship if Guardian:_____ Date:_____