Venus Ob-Gyn

Privacy Notice

AUTHORIZATION

I, (patient) _____, give permission for the following people to receive any confidential information regarding myself from Venus OB-GYN .

_____ Relationship:

_____ Relationship:

_____ Relationship:

_____ _____

Patient's Signature Date

Test results **may or may not (circle one)** be left on my answering machine/voice mail

Women and Infants Lab

We send all Pap Smears, biopsies, blood work, cultures, etc. to Women and Infants lab. If your insurance is not accepted at this facility, it is your responsibility to let us know. We cannot be responsible for lab bills that are denied by your insurance.

_____ You may send my labs to Women and Infants

_____ Other instructions: _____

Signature: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____

Patient/Legal Guardian Signature Date

Relationship (if not signed by patient): _____