



ACKNOWLEDGEMENT OF RECEIPT

Authorization for Disclosure/Notice of Privacy Practices

Patient Name: _____

The above named patient acknowledges receipt of Aishling Obstetrics & Gynecology, S.C. Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.

The above named patient understands that the practice reserves the right to change the privacy practices that are described in the Notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient.

Signature: _____ **Date:** _____

Relationship to patient: _____

NOTIFICATION OF TEST RESULTS

Please fill out this form which will detail how you would like our practice to disclose your personal information. It is the policy of our office to make available to you laboratory results, ultrasound and X-ray reports ordered by Aishling Obstetrics & Gynecology, S.C by phone or mail. If you have not heard from us in 14 days from the date of your test, please call our office.

Please check all acceptable options of notification of NORMAL test results:

_____ Patient
_____ Other: _____ Relationship: _____
_____ I would prefer to call you to obtain results.
_____ You may leave message on my answering machine or voice mail at the following # _____

Authorization to discuss personal health information:

In addition to myself, I authorize the staff at Aishling Obstetrics & Gynecology, S.C to discuss my personal health information, including abnormal test results with:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

Authorization to dispense medication(s):

I authorize _____ relationship: _____ to pick up my medication(s) or any correspondence from the office of Aishling Obstetrics & Gynecology, S.C.

*****Person authorized to pick up medication(s) must present a photo ID*****

Authorization to discuss billing information:

I authorize _____ relationship: _____ to discuss any billing information with the staff from my physician office or delegate from the billing service.

Please notify us of ANY CHANGES in the above.