COVINGTON
WOMEN'S HEALTH
SPECIALISTS

PATIENT ACKNOWLEDGEMENT AND
RECEIPT OF HIPAA PRIVACY NOTIFICATION

Covington Women's Health Specialists receives, creates or maintains certain individual health information used to arrange payment, carry out treatment, or to conduct hospital operations. Each individual has a right to read the notice required by general law which describes such uses and disclosures before signing this contract. Covington Women's Health Specialists reserves the right to change its privacy practices. The terms of our notice may change. To receive a revised notice please request a copy in writing to: Privacy Officer, Attn: Medical Records Department, 4181 Hospital Drive, Suite104, Covington, Ga. 30014.

Each individual may request restrictions on how personal health information is used or disclosed to carry out payment, treatment or health care operations. Covington Women's Health Specialists, LLC is not obligated to agree to any restrictions.

This acknowledgement is extended to individuals or entities that participate in a health care arrangement with Covington Women's Health Specialists, LLC. This includes, but is not limited to Alcovy Regional Homecare, Covington Pediatrics, Piedmont Physicians and entities or consulting in the facilities, Anesthesiologists, Pathologist, Radiologists, Speech Therapists, ER Physicians, Imaging Centers, Eligibility Specialists, Emergent & Non-emergent transport personnel and Home Health Practitioners.

I/we agree that I/we have received the HIPAA Privacy Notice for Covington Women's Health Specialists, LLC.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE FOREGOING, AND IS THE PATIENT OR DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Patient (print) _____ date _____

Patient (signature) _____ DOB _____

Patient representative _____ Relationship _____

Witness _____

COVINGTON WOMEN'S HEALTH SPECIALISTS

Consent to Release Information

The HIPAA Privacy act prevents us from disclosing information about you to others. Therefore, if you would like us to share any information with others (including family members) regarding your information please enter the required information and sign the form below. Unless this is signed, we cannot give information to anyone, including acknowledging that you are a patient.

If at any time you need to remove a person who you have given permission to receive your information, you must inform us in writing.

I, _____ give permission to Covington Women's Health Specialists, LLC to release and share information regarding my health status to the following person/people:

1. _____relationship_____

2. _____relationship_____

3. _____relationship_____

This consent covers all aspects of medical care.

Agreed to this _____day of _____, _____
(month) (year)

_____ _____
Patient's Signature Date of Birth

_____ _____
Print Name Date

_____
Witness