Notice of Privacy Practice

I acknowledge receipt of OB/GYN Centre of Excellence Notice of Privacy Practices. I authorize OB/GYN Centre of Excellence to use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

_____ _____

Patient Name Date

HIPPA Approved Contacts

I hereby authorize OB/GYN Centre of Excellence to communicate confidential health information and financial information to the following individuals:

First Name: _____ Last Name: _____ Relation:_____

DOB: _____ Gender: _____ Phone Number: _____

First Name: _____ Last Name: _____ Relation:_____

DOB: _____ Gender: _____ Phone Number: _____

First Name: _____ Last Name: _____ Relation:_____

DOB: _____ Gender: _____ Phone Number: _____