

Notice of Privacy Policy

I acknowledge receipt of OBGYN Centre of Excellence Notice of Privacy Practices. I authorize OBGYN 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. I understand I am enrolled in the HIPAA complaint texting service available.

Patient Signature Date

HIPAA Approved Contacts

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

First Name: _____ Last Name: _____
Relationship: _____ Date of Birth: _____
Phone Number: _____

First Name: _____ Last Name: _____
Relationship: _____ Date of Birth: _____
Phone Number: _____

Texting – Opt Out

I understand OB-GYN COE provides a HIPAA compliant texting service; however, I do not wish to participate at this time.

Patient Signature Date