CORDELL MITHCELL, M.D.
OBSTETRICS & GYNOCOLOGY

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

Patient Name (Print) _____

Signature _____

Date: _____

Witness: _____

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Dr. Cordell Mitchell, M.D. OBGYN and staff in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revise Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restriction(s) are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are ether my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: _____

_____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to Dr. Cordell Mitchell, M.D. and staff releasing information to me in the following alternative manner (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.)_____

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

_____ Via fax to my designated fax number which is: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) does not sign this Consent Form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you at the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorize party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ AM/PM

_____

Signature of Patient or authorized representative

_____

Please print Name

*Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

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