MERCED OBGYN CARE, INC.

KRISTINA SOGOCIO, M.D.

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PRIVACY POLICY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those who we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we may have indirect treatment relationships with you (such as laboratories, radiology and pathology) that only interact with physicians and not patients and we may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information (PHI), but this must be in writing. Under the law effective April 14, 2003, we have the right to refuse to treat you should you choose to refuse disclosure of your (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy.

Print Name: _____ Signature: _____ Date: _____

(If patient is under 18 years of age, a parent or guardian must sign).
(This policy expires ten years from the original date signed).

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CONSENT FORM

Patient Name: _____ **DOB:** _____

I authorize the following person to represent me at Merced ObGyn Care, Inc. if I am unable to personally authorize medical services for myself. This authorization is valid until withdrawn in writing.

_____

Name (other than person completing this form) Relationship to patient Phone

Other authorization instructions if any: _____

_____

Authorization for Test Results (By checking the box you are authorizing us to leave a message):

Abnormal	Normal	
☐	☐	Home Telephone _____
☐	☐	Work Telephone _____
☐	☐	Cell Phone_____
☐	☐	Email Address _____
☐	☐	Other contact (name, relationship, phone number) _____