

Date: _____ Chart #: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.

**ACKNOWLEDGEMENT OF REVIEW
OF NOTICE OF PRIVACY PRACTICES**

I have reviewed and/or received a copy of the **Notice of Privacy Practices** for OB/GYN Professionals of East Tennessee and authorize the release of my **Protected Health Information** as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

OB/GYN Professionals of East Tennessee has my permission to leave appointment and medical information (**INCLUDING NORMAL TEST RESULTS**) with:

Please initial each method that you approve.

_____ Anyone in my home.

_____ Spouse/partner only

_____ At home answering machine.

_____ Patient only

_____ At work answering machine or voicemail.

_____ Cell phone/voicemail

NAME OF PATIENT (Please print)

SIGNATURE OF PATIENT (Please print)

DATE

Signature of patient representative (Required if the patient is a minor or an adult who is unable to sign this form)

RELATIONSHIP: _____