

Axia Women's Health  
**HIPAA**  
**Acknowledgments and Authorizations**

**I. HIPAA Notice of Privacy Practices**

***Patient Acknowledgment***

Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that I have been given the option of receiving a copy or been afforded an opportunity to review Axia's Notice of Privacy Practices:

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**II. Authorization for use or Disclosure of Health Information**

***Patient Contact Information***

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

I authorize **brief messages** with medical information to be left on voicemail at (check all that apply):  Home  Cell  Work

I authorize **extended messages** with medical information to be left on voicemail at (check all that apply):  Home  Cell  Work

Restrictions/Instructions: \_\_\_\_\_

***Release of Medical History and Treatment Information***

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Please use my emergency contact on the patient demographic form.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

The above individual(s) may receive information across all Axia care centers unless otherwise noted: \_\_\_\_\_

***Release of Billing Information***

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Please use my emergency contact on the patient demographic form.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

The above individual(s) may receive information across all Axia care centers unless otherwise noted: \_\_\_\_\_

***Parent / Guardian Information***

Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

***Patient Acknowledgment***

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance with the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

***Additional Authorizations***

I request a female chaperone to be present during my examination?  Yes  No  Other \_\_\_\_\_