Denton Obstetrics & Gynecology

HIPAA CONSENT FORM

Patient Name: _____ **Date of Birth:** _____/_____/_____

Phone Calls. By providing contact information, I authorize Denton Obstetrics and Gynecology, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/ artificial/voice messages and/or auto-dialing devices in connection with any communication to me.
Involvement of Others in Care. I authorize Denton Obstetrics and Gynecology to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

PRIMARY PHONE #	SECONDARY PHONE#
☐ Leave message with contact number only.	☐ Leave message with contact number only.
☐ Leave a message with detailed information.	☐ Leave message with detailed information.
☐ Do not leave message.	☐ Do not leave message.

Notice of Privacy Practices
I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable) **Parent Initials:** _____
I consent for Denton Obstetrics and Gynecology to photograph the minor patient for identification purposes only.

Print Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Date: _____