Catherine Holt M.D.
OBSTETRICS/GYNECOLOGY

Acknowledgement of Receipt of Privacy Notice- HIPPA

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can, and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are obliged to abide by such restrictions.

Authorization for Use and Disclosure of Protected Health Information

I_____, hereby authorize, Catherine A. Holt, M.D., P.A. to use and/or disclose the following **protected health information (PHI)** to:

Name_____ Relationship_____

Name_____ Relationship_____

□ **I DO NOT** authorize Dr.Holt to release my PHI to anyone other than myself. I understand that by doing so it may take longer to get results.

May we leave a voicemail regarding medical information and/or financial responsibility? □ YES □ NO □ Cell □ Home □ Work

This PHI is being used or disclosed for the following purposes:

Provide appointment reminders and financial responsibility.
Describe or recommend treatment alternatives
Provide information about health-related benefits and services that may be of interest to the individual.
Soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization. The use or disclosure requested in this authorization will result in direct and indirect compensation to **Catherine A. Holt, M.D., P.A.** from a third party. This authorization will remain in effect until further notice from patient or legal guardian of the patient.

_____ _____

Signature of the Patient or Representative/Guardian Date

_____

Printed Name of Patient or Representative/Guardian