Women's Center of Florida
An Emory Medical Corporation

Dr. Chandler Mehan, MD
Dr. Emad Atta, MD

4812 W US HWY 90, LAKE CITY, FL 32055
Phone: (386)466-1106
web: www.myOBcare.com

PO BOX 1646, LAKE CITY, FL 32056
Fax: (386)466-1821

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NICA DISCLOSURE

I hereby acknowledge that I received a copy of Women's Center of Florida's Notice of Privacy Practices.

NICA DISCLOSURE PHYSICIAN NOTICE TO OBSTETRICS PATIENTS SEE SECTION 766.314, FLORIDA STATUES

I have been furnished information on behalf of all Women's Center of Florida physicians who practice obstetric services, which has been prepared by the Florida Birth Related Neurological injury Compensation Association (NICA). I have also been advised that the Women's Center of Florida physicians who practice obstetrics or perform obstetric services are participation physicians in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery, or resuscitation. For specifics on the program, I understand I may contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), Post Office Box 14567, Tallahassee, Florida 32317-4567, 800-398-2129. I specifically acknowledge that I have received a copy of the brochure prepared by NICA.

I understand the NICA disclosure and all of my questions and/or concerns have been answered. I also acknowledge the receipt of HIPPA notice of Privacy Practices. I have read the copy of Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

All consents/agreements signed will be stored electronically and will be valid for all treatment encounters, for all practice providers and at all practice locations. I willfully and voluntarily give the information above. I understand that it is my responsibility to keep my contact information current. Any changes made by me after this date will be done so by me in writing only. I also understand all the forms/consents/agreements are available on the practice website, www.myobcare.com, for my review and or a copy available to me at my request.

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Legal Representative Signature Telephone Number

If not signed by the patient, please indicate relationship:

____ Parent or guardian of minor patient

____ Guardian or conservator of an incompetent patient

For Office Use Only:

Signed form received by: _____ _____ _____

Signature Printed Name Date

WOMEN'S CENTER OF FLORIDA
EMORY MEDICAL CORPORATION
PATIENT REGISTRATION & CONSENT FORM

AUTHORIZATION FOR DISCLOSURE
OF PROTECTED MEDICAL INFORMATION

Patients Name _____ Date of Birth _____ Date of Authorization _____

For the Patient: I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information my contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release of exchange of this information with the person or organization named below.

I understand that I may revoke this authorization at any time by notifying the Privacy / Compliance Officer at Women's Center of Florida in writing. However, the revocation will not have an effect on any actions Women's Center of Florida took before receiving the revocation.

I authorize Women's Center of Florida to disclose my protected health information to the following persons or organization (this is not a medical records request or authorization):

Name of Person/ _____ Phone Number _____

Name of Person/ _____ Phone Number _____

Description of individually identifiable health information to be received or disclosed (check all that apply):
____ Treatment Plan(s) ____ Progress Reports ____Appointments ____ Other (describe) _____

The purpose of this authorization (check all that apply):
____To allow the appropriate management of treatment or services ____Other (describe): _____

This authorization is effective for disclosure of information from the date of signature. Its effective date is good through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Emergency Contact Information (This section is NOT an authorization to disclose PHI):

Name of Person _____ Relationship _____ Primary Phone Number _____ Alternate Phone Number _____

Physical Address _____ City, State, Zip code _____

Printed Name of Patient/Authorized Representative _____ Signature _____ Date _____