Oakland Macomb Obstetrics & Gynecology, P.C.
Acknowledgement of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have **received** a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, and who will be able to answer my questions.

Privacy Officer
Sherry Melenovsky
1701 South Boulevard East, Suite 200
Rochester Hills, MI 48307
(248) 997 - 5805

I request the following person(s) to receive information regarding my protected health information:

Name _________________________ Relation ____________________ Birth Date _____

Name _________________________ Relation ____________________ Birth Date _____

You as a patient have the right to:

1. Inspect and copy your medical information that may be used to make decisions about your care.

2. Request an amendment to your medical record if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for her/his denial.

3. Request an accounting of disclosures. This is a list of disclosure for other than treatment, payment or health care operations.

4. Request a restriction or limitation on the medical information used or disclosed about me for treatment, payment or health care operations. All requests must be made in writing. However, the physician has the right to deny the restriction. If she/he does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

Print Patient Name ____
Signature ______________________________ Date _______________

Office use only:
____ Patient refused to sign consent, despite a good faith effort to receive acknowledgment.
Employee Signature __________________________ Date _______