MAGNOLIA OBSTETRICS AND GYNECOLOGY, PLLC
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Patient Initials	
_____	**RECEIPT OF NOTICE OF PRIVACY PRACTICES** **WRITTEN ACKNOWLEDGEMENT FORM** **I, _____ acknowledge confirmation and receipt of the office privacy practices for the office of Magnolia Obstetrics and Gynecology, PLLC.**
_____	**PRIVACY CONSENT** **I authorize the Office of Magnolia OB/GYN to release the following information to:** _____ **please include full name and relationship. (i.e. Joe Smith- spouse, or Jane Smith- mother, ect…)** **_____ Medical Information Only** **(including but not limited to all test results, office/clinical notes, medications, and correspondence)** **_____ Financial Information Only** **_____ All Medical and Financial Information**
_____	**TEST RESULTS** **Do you want your results by phone call? YES or NO** If **YES** , what number can we leave a **detailed voicemail** with your results on? **(#)**_____ If NO, we will mail a letter to the address on file in our system. Please make sure you have given us your current mailing address before you are seen by the physician.
_____	I also understand that it is my responsibility to update the office with any changes in personal, medical, financial, or contact information.

By signing below, I confirm I have read, understand, and have given correct information to the best of my ability.

_____ _____
PATIENT NAME PRINTED **DATE**

SIGNATURE OF PATIENT_____