KENNESAW
GYNECOLOGY

## Permission for Test Result Notification

Patient confidentiality is a top priority in this office. Therefore, it is important that we know exactly how you would like to be contacted by this office with test results. Patients 17years old and younger will need their parent or guardian to complete this information.

Please contact me at _____ with any test results.
(Daytime phone number)

If I am unavailable at this number you ***MAY,*** or ***MAY NOT*** leave a message on my voicemail.
(Circle one)

Consent to text appointment reminders? ***YES*** or ***NO*** (Circle One)
Cell Number: _____

If there is any other person that we may talk to regarding your test results if you are not available, please list them below. If you wish us only to speak with you, please write no one.

| Person's Name | Relationship to you | Their Daytime phone number | May we leave a voicemail message on this number? **YES** or **NO** |
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## Electronic Medical Record

Our practice, Kennesaw Gynecology LLC, utilizes electronic medical records to make sure we are in compliance with all federal laws. We utilize pharmacy interface allows us to obtain your medication history from your pharmacy to keep us up to date on your current medications. We utilize a patient portal to have a more secure way to transfer and receive information with our patients. Lastly, we utilize an interface with Georgia Department and Human Resources to keep your vaccination record up to date.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the doctor or staff.

## Consent for Release of Information for Treatment, Payment and Healthcare Operations

*(For Insurance Purposes)*

I consent to the use disclosure of my protected health information by Kennesaw Gynecology LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations of Kennesaw Gynecology.

I have the right to revoke this consent in writing at any time, expect to the extent that Kennesaw Gynecology has taken action in reliance on this consent.

My "protected health information" means that health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Print Name: _____ DOB: _____

Patient Signature: _____ Todays Date: _____
(If 17 years old or younger parent or guardian must sign)