Mayur V. Patel, M.D., F.A.C.O.G

Obstetrics & Gynecology

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Acknowledgement of Receipt of Notice of HIPAA Privacy

I, ____, acknowledge that I have been provided with a copy of the Notice of HIPAA Privacy.

Date: _______________________

Patient Name: ____

Date of Birth: ____

Signature of Patient/Parent/ Guardian: _____________________________________

MEDICAL RELEASE (including minors)

I hereby authorize Dr. Mayur V. Patel to furnish information and/or discuss information contained in my medical record, including appointment information, with the following person or persons: (Include nurse case managers, if applicable.)

YOU MUST LIST NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN TALK TO REGARDING YOUR CARE!

IF NO ONE IS LISTED BELOW, WE CAN NOT DISCLOSE ANY INFORMATION UNDER ANY CIRCUMSTANCE.

Name: ____Relationship:________________________________

Name: ____Relationship:________________________________

Name: ____Relationship:________________________________

Name: ____Relationship:________________________________

Name: ____Relationship:________________________________

Name: ____Relationship:________________________________

Revision Date February 2009