Gifts From Grace OBGYN, LLC.

Patient Name: _____ DOB: _____

Privacy Notice

I, _____, have received a copy of the "Notice of Privacy Practices" to review.

_____ _____

Patient or Guardian Signature Date

Contact Information

☐ Please do not release my information to anyone other than myself unless specified below. I understand that Gifts From Grace may leave a non-detailed message on my answering machine to contact the office.

☐ I give Gifts From Grace permission to release my IIHI to the following person(s) or entity(ies) (Please note any restrictions. i.e.: none; detailed messages; please contact the office notice; financial information; appointment information.):

_____

_____

_____

☐ I would like Gifts From Grace to contact me at the following number if possible:

(_____) _____ - _____.

This is my ☐ Home ☐ Cell ☐ Work or ☐ Other _____

_____ _____

Patient or Guardian Signature Date