plaza OB/GYN www.plazaobg.com PH: 713.522.3333 FX: 713.522.4434 1801 BINZ STREET, SUITE 500 HOUSTON, TEXAS 77004

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

According to Federal Regulation called HIPAA, we are not allowed to release any information about our patient to anyone else. Only the patient can get their information, unless we have a consent signed by the patient to release their information to any other designated person.

I **am allowing / not allowing** the following to have access to my medical chart:

_____
_____
_____
_____

_____ _____
Signature Date