MID-MISSOURI REPRODUCTIVE MEDICINE & SURGERY

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witness by: _____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

Patient refused to sign this Acknowledgement.

Date:_____ Time:_____

Employee Name:_____

MID-MISSOURI REPRODUCTIVE MEDICINE & SURGERY

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Mid-Missouri Reproductive Medicine and Surgery, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mid-Missouri Reproductive Medicine and Surgery, Inc. I understand that diagnosis or treatment of me by Mid-Missouri Reproductive Medicine and Surgery Inc., may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mid-Missouri Reproductive Medicine and Surgery, Inc., is not required to agree to the restrictions that I may request. However, if Mid-Missouri Reproductive Medicine and Surgery, Inc., agrees to a restriction that I request, the restriction is binding on Mid-Missouri Reproductive Medicine and Surgery, Inc., and _____.

I have the right to revoke this consent, in writing, at any time, except to the extent that Mid-Missouri Reproductive Medicine and Surgery, Inc., has taken action in reliance on this consent.

My "protected health information" means 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 a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information ay identify me.

I understand I have a right to review Mid-Missouri Reproductive Medicine and Surgery, Inc.'s, Notice of Privacy Practices prior to signing this document. The Mid-Missouri Reproductive Medicine and Surgery, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Mid-Missouri Reproductive Medicine and Surgery, Inc., is also provided at the front office area. This Notice of Privacy Practices also describes my rights and Mid-Missouri Reproductive Medicine and Surgery, Inc.'s, duties with respect to my protected health information.

Mid-Missouri Reproductive Medicine and Surgery, Inc., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority