706 W Platt St Tampa, FL 33606
Ph. 813-251-2000 Fax 813-283-6700

HIPAA FORM

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PERMISSION TO SHARE HEALTH INFORMATION.

I have read the OMNI Medical Center for Women Notice of privacy Practices Act. I understand that I may have a copy upon request.

____ _______________________

Patient Name Date of Birth

____ _______________________

Signature Date

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize OMNI Medical Center of Women to disclose my health information to the following person(s):

1.____

2.____

3.____

____

Signature

RESTRICTIONS ON THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

As further described in the OMNI Medical Center for Women Notice of Privacy Practice, I understand I may request certain restrictions on the use and disclosure of my health information. I request the following restrictions.
OMNI Medical Center for Women is not required to agree to my requests.

1.____

2.____

3.____

____

Signature

Expires one year from date signed