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PLEASE SIGN THIS FORM TO ACKNOWLEDGE THAT WE HAVE PROVIDED YOU WITH A COPY OF THE OHIO REPRODUCTIVE MEDICINE NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes your rights in regard to your health information, the possible uses of your health information, and how we must protect confidentiality of your health information.

THIS IS NOT A CONSENT

BY SIGNING THIS DOCUMENT, YOU ARE ONLY STATING THAT WE HAVE PROVIDED YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES. IF YOU WISH TO RECEIVE A COPY OF THIS FORM, ASK THE REGISTRATION/SCHEDULING STAFF MEMBER WHO IS ASSISTING YOU.

We encourage you to carefully read the full Notice. You may also access our Notice of Privacy Practices on our website: *www.ohioreproductivemedicine.com*. This website is also listed on the Notice.

I have been given the Ohio Reproductive Medicine Notice of Privacy Practices:

Signature: ____ Date: ______________________

Authorized Agent: ____ Relationship to Patient: _________

Documentation of Attempt: ____

SUMMARY OF THE NOTICE OF PRIVACY PRACTICES
NOTE: THIS INFORMATION IS DESCRIBED IN DETAIL IN THE NOTICES OF PRIVACY PRACTICES

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

We may use and share your information as we:

- Treat you
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Run our organization
- Bill for your services
- Help with public and safety issues
- Do research
- work with a funeral director
- respond to organ and tissue donation request
- comply with the law