



**Women's OB/Gyn Center**  
 5119 Fairmont Parkway • Pasadena, TX 77505

Tel (281) 991-7603 • Fax (281) 991-7675

**Patient Confidentiality Statement**

Patients of Women's OB/Gyn Center have the right of patient confidentiality on all medical information and laboratory results. All information shall be held in confidential and shall not be disclosed to any person, except upon the expressed consent of the patient or by the guidelines of his/her medical insurance. All biopsy reports, and laboratory results will only be given to the PATIENT unless otherwise noted below. If the patient is a minor, all information will be explained to the parents or legal guardian.

\_\_\_\_\_  
**Patient Name**

The following individuals are authorized to access my medical information:

<b>SPOUSE</b> _____	<b>Birth Date</b> _____
<b>SON</b> _____	<b>Birth Date</b> _____
<b>DAUGHTER</b> _____	<b>Birth Date</b> _____
<b>OTHER</b> _____	<b>Birth Date</b> _____

**CAN WE MAIL CORRESPONDENCE ON YOUR HOME? YES \_\_\_\_\_ NO \_\_\_\_\_ (Initial one)**  
**CAN WE LEAVE A MESSAGE ON YOUR HOME RECORDER? YES \_\_\_\_\_ NO \_\_\_\_\_ (Initial One)**

**Acknowledgment of Receipt of Notice of Privacy Act**

I, \_\_\_\_\_ have received the Notice of Privacy Practices from Women's OB/Gyn Center.

\_\_\_\_\_  
 Signature Date

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Women's OB/Gyn Center, state that \_\_\_\_\_ has been given our current copy of Notice of Privacy Practices.

\_\_\_\_\_  
 Signature Date