

**Modern Obstetrics & Gynecology of North Atlanta, P.C.**

John C. Reyes, M.D.

Ingrid V. Reyes, M.D.

**Patient Consent and Acknowledgment of Receipt of Privacy Notice**

I, \_\_\_\_\_ understand that as a part of the provision of healthcare services, Modern Obstetrics & Gynecology of North Atlanta, P.C. creates and maintains health records describing my health information. This includes but is not limited to my health history, symptoms, diagnoses, examination and test results, treatment, and any plans for future treatment.

I have read and/ or have been provided with a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health care information.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

Patient Printed Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize and give permission to Modern Obstetrics & Gynecology of North Atlanta, P.C., to disclose and discuss any information related to my medical condition(s) to/ with the following persons:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship