COBB WOMEN'S HEALTH

Nandita Mainthia, M.D.
F.A.C.O.G.

Hitendra R. Hansalia, M.D.
F.A.C.O.G.

ACKNOWLEDGEMENT OF RECEPIT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices for the office of Cobb Women's Health, P.A. and understand I may request a copy to have for my records if so desired.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

1810 Mulkey Road, Suite 102, Austell, Georgia 30106-1132
Tel: (770) 944 8660 **Fax:** (770) 944 8661

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COBB WOMEN'S HEALTH, P.A.
NANDITA MAINTHIA, M.D.
HITENDRA HANSALIA, M.D.

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by Nandita Mainthia, M.D., and Hitendra Hansalia, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the office of Cobb Women's Health, P.A.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of Cobb Women's Health, P.A. 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 healthcare clearinghouse. This protected healthcare information relates to my past, present or future physical or mental condition and identifies me, or this is a reasonable basis to believe this information may identify me.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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