Tania White Jackson, M.D.
Obstetrics & Gynecology

CONSENT FORM

I acknowledge that I have read the following forms at www.drjacksonobgyn.com that I understand the information therein.

1. Office Policy Statement
2. HIPPA Statement
3. Medical Provider Statement

HIPPA CONSENT
Federal Law ensures the privacy of your medical records, their availability to you, and specific rights regarding your medical records**.**

The practice of **Dr. Tania A. White Jackson** complies with these standards. As a general principle, we will always assume that you have instructed us **NOT** to release your medical records, or any portion thereof, to anyone, except under the usual, general circumstances covered below. Please read and sign this:

GENERAL AUTHORIZATION CONCERNING YOUR MEDICAL RECORDS.
Relevant portions of my medical record may be provided to:

1. Other designated doctors and their staffs (e.g., this practice, primary or referring doctors and their staffs; hospital or out-patient facilities, or surgical-day-care).
2. My medical insurance company to document specific service(s) provided and billed.
3. The Government, as required by law (e.g., subpoena)

Please designate the names of any people you wish to have access to your records:
Name 1:_____
Name 2:_____

Please check the appropriate box (es) below to indicate the method you prefer to be contacted to discuss any information pertaining to your health.

Home: _____Cell:_____ Work:_____ Email: _____

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any of the above methods.
Print Name: _____ Signature: _____ Date: _____