NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
OBSTETRICAL & GYNECOLOGICAL ASSOCIATES, INCORPORATED
Diplomates of the American Board of Obstetrics and Gynecology

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice.*

I understand that I may request in writing that the use of my private information be restricted. I understand that the organization is not required to agree to my requested restrictions if they hinder treatment, payment or healthcare operations. However, if consent is granted to the restrictions, they are binding.

Patient Name ____

Relationship to Patient ____

Signature ____ Date ____________________

I attempted to receive consent for the HIPAA form above, but was unable to do for the reason listed below.

Staff Member Name ____

Date ______________________________ Reason ___________________________________