Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

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

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare 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 your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.
- I acknowledge that I have been provided or refused a copy of Advanced Women's Health of Nashville's Notice of Privacy Practices, which has been effective and current since October 1, 2016; and which describes how my health information may be used and disclosed.

I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at any time or online at www.womenshealthnashville.com to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my protected information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:_____Initials:_____Reason:_____
