GynOb associates

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a Notice of Privacy Practices (as required by HIPAA) from GYN-OB Associates. This notice contains a more complete description of the uses and disclosures of my health information. GYN-OB Associates has the right to change its Notice of Privacy Practices to reflect current business practices. The Notice of Privacy Practices will be posted in our office and I understand I may request a copy at any time.

Signed: _____ Date: _____

◯ Patient ◯ Guradian ◯ Guardian ◯ Executor

Witness: _____ Date: _____

FOR OFFICE USE ONLY

A good faith attempt was made to obtain the patient's signature in acknowledgement for the receipt of the Notice of Privacy Practices, however the patient refused.

Signature: _____ Date: _____

Witness: _____ Date: _____

Additonal comments if necessary _____

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