Acknowledgement of Review of Notice of Privacy Practices

Affiliates For Women's Health
1602 Rock Prairie Rd #430
College Station TX 77845
(979) 693-0737

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

*Provide and coordinate my treatment among a number of health care providers

*Obtain payment from third-party payers for my health care services

*Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are to abide by such restrictions.

Patient Name _____ Date _____

Signature _____ Relationship _____

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For Office Use:

We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

___ the patient refused to sign ___ communication barriers ___ emergency situation ___
___ other _____