SWOR WOMEN'S CARE
Gynecology • Obstetrics • Infertility • UroGynecology

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 understand that this organization has the right to change the notice of Privacy Practices from time to time and that I may contact this organization at any time 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 other 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.

I,_____, give Swor Women's Care permission to release private health information and test results to the person(s) listed below, in the event that I am unreachable.

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Name (please print) _____
Patient Signature_____
Date _____
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OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date _____
Initials _____
Reason _____