Women's Healthcare Consultants of Gwinnett, PC

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of understanding of Women's Healthcare Consultants Privacy Practices

Patient's Name: ______________________________ Date of Birth: ______________

SSN: ______________________ Maiden Name: ______________________________

I understand that Women's Healthcare Consultants of Gwinnett may use and disclose the patient's personal health information to help care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Women's Healthcare Consultants of Gwinnett has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgement.

Women's Healthcare Consultants of Gwinnett may update this Acknowledgement and "Notice of Privacy Practices". If I ask, Women's Healthcare Consultants of Gwinnett will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communication or alternative location.

Women's Healthcare Consultants of Gwinnett has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist by following these procedures if I chose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Women's Healthcare Consultants of Gwinnett's "Notice of Privacy Practices".

______________________________________ ______________________

Patient or Legal Authorized Signature Date

Relationship to patient if signed by anyone other than the patient: ______________________