NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

# NAME DATE DATE OF BIRTH

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 have had the opportunity to understand your Notice ofPrivacy Practices containing a more complete description of the uses and disclosures of my health information. 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 at the address below to obtain a current copy of the Notice ofPrivacy 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you arc bound to abide by such restrictions.

#  SIGNATURE RELATIONSHIP TO PATIENT

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

#  DATE INITIALS REASON

Patients 18 and over must complete the following:

I hereby authorize Center for Women 's Health (MAWC) to use or disclose the following:

  HealthCare (Z Other

My protected health information may be disclosed to:

(List all Names)

This protected health information is being used or disclosed to provide healthcare.

This authorization shall be in force and effective until: (check one of the following) No expiration C] Other

I understand that, as set forth in MAWC's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Center för Women 's Health, 12706 McManus Blvd, Newport News, VA 23602

I understand that I have the right to:

* Inspect or copy my protected health information to be used or disclosed as permitted under federal law

(or Virginia law).

* Refilse to sign this authorization.

#  OF OR REPRESENTATIVE OATE

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