Gallatin Women's Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability ACT of 1996 ("HIPPA"), 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 received, read and understand your *Notice of Privacy 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 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 healthcare 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.

Print Patient Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

I _____ (patient name), give permission for Gallatin Women's Center, P.C. (Drs. Caldwell, Bennett, Felton and staff) to discuss anything regarding my medical care with the following person(s).

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

In addition, I give permission for Gallatin Women's Center, P.C. to call me or leave a message for me for the purpose of notification of laboratory results or appointment reminders at the following numbers:

Home Phone: _____ Cell Phone:_____

Emergency Contact:_____

Name Phone Number

_____

Signature (Must be patients no matter age) Date

Office Use only:

I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices* but was unable to do so as documented below.

Date:_____ Initials:_____Reason:_____