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Diplomate
American Board
Obstetrics and Gynecology

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PH) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

_____	_____	_____
Please Print Your Name	Date	Please Sign Your Name

_____	_____	_____
Legal Representative	Date	Description of Authority

Office Use Only

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

It was emergency treatment _____
Inability to communicate with patient _____
Patient refused to sign _____ Because _____
Patient was unable to sign _____
Other: _____