

Acknowledgement of Privacy Practices

I acknowledge that I have been notified of Gynecologic Surgeons and Obstetricians, P.C.'s Notice of Privacy Practices which describes how my health information may be used or disclosed. I understand Gynecologic Surgeons and Obstetricians, P.C. reserves the right to change the notice and its privacy practices at any time. Copies of the Notice of Privacy of Practices are located on the front desks of Gynecologic Surgeons and Obstetricians, P.C.'s, if I would like a copy they are available at the front desk.

Signature of Patient/Responsible Party

Date

Print Name

Patient unable to sign because _____

Good Faith Effort

- Presented the Notice of Privacy Practices to the patient/responsible party, but the patient/responsible party declined to acknowledge receipt.
- The Notice of Privacy Practices was mailed to the patient/responsible party.
- Other _____

Signature of Gynecologic Surgeons and
Obstetricians, P.C. Representative

Date