THE FEMALE PELVIC HEALTH CENTER

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how The Female Pelvic Health Center may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves their right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their PHI, but the Practice does not have to agree to those restrictions.

I give permission for The Institute for Pelvic Medicine & Reconstructive Surgery to:

_____ Leave a message regarding an appointment at your designated phone number.
(Note: This is only an automated reminder of your appointment. No clinical information will be released).

_____ Share medical information with:

Name ____

Relationship ____

Name ____

Relationship ____

I assume responsibility to inform The Female Pelvic Health Center of any changes in the above information.

Print Patient's Name	Date:
Signature	Relationship to Patient (if other than patient:
Witness:	