ADVANCED OBSTETRICS & GYNECOLOGY, L.L.C.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 amount 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 reviewed, 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 Advanced Obstetrics & Gynecology, L.L.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact Advanced Obstetrics & Gynecology, L.L.C. at any time at the address below 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 health care 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

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

Date: _____ Initials: _____

Reason: _____

I failed to give the patient a copy of the Notice of Privacy Practices:

Date:_____ Initials:_____ Date Mailed:_____