PRIVACY POLICY STATEMENT

I hereby acknowledge that I have been made aware that Peachtree Women's Specialists has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Peachtree Women's Specialists (PWS), I understand and acknowledge the following:

1. PWS has a privacy policy in effect in their office
2. PWS has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting area and/or by placing a poster of this policy in the waiting area or similar common area with patient access.
3. PWS has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon review of the above statements, please sign the bottom acknowledging that you have been advised of the Privacy Policy implemented by PWS and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.

_____**No**. I do not want a copy but acknowledge the Privacy Policy exists.

_____**Yes**. I do want a copy of the Privacy Policy.

_____ _____ _____

Patient Name (print) **Patient Signature** **Date of Birth**

I understand that as part of my healthcare PWS will need to contact me in order remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize PWS to contact me in the following ways (check boxes which you authorize).

_____Home Phone _____ Voicemail OK _____

_____Cell Phone _____ Voicemail OK _____

_____Work Phone _____ Voicemail OK _____

I understand that Peachtree Women's Specialists will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize Peachtree Women's Specialists to discuss matters relating to my condition/care with the following persons:

_____ _____

Name (Please Print) Relationship to Patient

_____ _____

Name (Please Print) Relationship to Patient

_____ _____

Patient Signature **Date**