

# Notice of Privacy Practice Acknowledgement

## MIAMI GLOBAL OB/GYN, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

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Patient Name or Legal Guardian (print)

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Date

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Signature

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### Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: \_\_\_\_\_ Attempt: \_\_\_\_\_

Staff Name: \_\_\_\_\_