



ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Acknowledgment of Notice

I acknowledge that I may access West Augusta Obstetrics & Gynecology, P.C. Notice of Privacy Practices online or request a copy from office staff. I understand that the Notice describes how the practice may use and disclose my protected health information and describes my privacy rights.

I understand that my signature acknowledges receipt of the Notice only. It does not constitute authorization for uses or disclosures of my health information beyond those permitted by law, and it does not waive any privacy rights.

I understand that I may request a paper or electronic copy of the current Notice at any time. A copy of the Notice is available online at westaugustaobgyn.com.

Patient Information

Patient Name: _____

Date of Birth: _____

Persons Authorized to Receive or Discuss My Health Information

I authorize West Augusta Obstetrics & Gynecology, P.C. to communicate with and disclose health information to the person(s) listed below, to the extent permitted by law. I understand that some disclosures or release of medical records may require a separate written HIPAA authorization.

Name	Relationship	Phone Number

Patient or Personal Representative Signature

Signature

Date

If signed by a Personal Representative

Name: _____

Relationship/Authority: _____

For Office Use Only

☐ Notice provided/available to patient or personal representative.

☐ Acknowledgment obtained.

☐ Patient/personal representative declined or was unable to sign; good-faith effort documented in the medical record.

If the patient or personal representative declines to sign, care is not conditioned on signing this acknowledgment. Staff should document the good-faith effort to obtain acknowledgment and the reason it was not obtained.