Georgia Advanced Surgery Center for women
Experts in Minimally Invasive Gynecological Care

HIPAA ACKNOWLEDGMENT FORM

PATIENT'S

NAME:_____

DATE OF BIRTH:_____

ACKNOWLEDGMENT OF HIPAA RIGHTS

I DO HEREBY ACKNOWLEDGE THAT **GEORGIA ADVANCED SURGERY CENTER FOR WOMEN** HAS PROVIDED ME WITH A NOTICE OF ITS PRIVACY PRACTICES, AS REQUIRED BY FEDERAL LAW (HIPAA). I UNDERSTAND THAT GEORGIA ADVANCED SURGERY CENTER WILL, UPON REQUEST, PROVIDE ME WITH A COPY OF THE PRIVACY POLICY.

SIGNED:_____

DATE:_____

CONFIDENTIALITY NOTICE

IT IS IMPORTANT FOR US TO HONOR THE CONFIDENTIALITY BETWEEN PATIENT AND PHYSICIAN. **PLEASE CHECK YOUR PREFERENCE BELOW.**

_____ YOU MAY DISCUSS MY MEDICAL INFORMATION ONLY WITH ME.

_____ I GIVE MY PERMISSION TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

1. _____ RELATIONSHIP:_____
2. _____ RELATIONSHIP:_____
3. _____ RELATIONSHIP:_____

_____ YOU MAY LEAVE MEDICAL INFORMATION (TEST RESULTS, APPOINTMENT TIME, ETC.) ON MY VOICEMAIL AT:

CELL#:_____

HOME#:_____