AZ UROGYNECOLOGY & PELVIC HEALTH CENTER
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand this information can be used to:

- Conduct, plan and direct my treatment and also assist with follow-up among the multiple health care 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 read and understand **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** has the right to change its Notice of Privacy Practices from time to time and that I may contact **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** at any time and obtain a copy of a current copy of the Notice of Privacy Practices.

I understand that I may request in writing a requisition of particular restrictions that I would like to be applied to the use and disclosure of my private information as it is used to carry out treatment, payment or healthcare options. I also understand **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** is not required to agree to my requested restrictions. However, if **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** does not agree, **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** is still bound to abide by such restrictions.

I agree that **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** may discuss my medical information and/or insurance information with;

Name: ____________________________________ Relationship: ____

Name: ____________________________________ Relationship: ____

Patient Name: ____ Date: ___________________________

Signature: ____ Relationship: _____________________