THE INSTITUTE FOR FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how The Institute for Female Pelvic Medicine & Reconstructive Surgery may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves their right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI, but the Practice does not have to agree to those restrictions.
- The patient has the right to restrict the use of their PHI with insurance companies about tests or treatments for which they have paid for out-of-pocket.
- The patient has the right to obtain copies of their health information within 30 days of their request, with one (1) 30 day extension permitted.
- The patient has the option to access their health information electronically through The Institute for Female Pelvic Medicine & Reconstructive Surgery's portal website for patients.

I give permission for The Institute for Pelvic Medicine & Reconstructive Surgery to:

_____ Provide appointment conformations by phone, mobile text and email

(Note: This is only an automated reminder of your appointment. No clinical information will be released)

_____ Share medical information with:

Name: _____

Relationship: _____ Contact number(s): _____

Name: _____

Relationship: _____ Contact number(s): _____

_____ **I DO NOT WANT** to receive appointment conformations

_____ **I DO NOT WANT** my medical information shared

I assume responsibility to inform The Institute for Female Pelvic Medicine & Reconstructive Surgery of any changes in the above information.

Print Patient's Name	Date:
Signature	Relationship to Patient (if other than patient):
Witness:	