RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received a copy, or have been given the option of receiving a copy of our Notice of Privacy Practices, (HIPPA).

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Patient's Name (please print)

____ _____________________

Signature of Patient or Legal Guardian **Date**

I give permission to West Georgia Obstetrics and Gynecology, P.C., to disclose any information regarding my treatment to the following people in the event that they may need information about me over the telephone or in person:
****PLEASE PRINT NAMES BELOW****

___ Spouse _____________________________________

___ Parent _____________________________________

___ Child(ren) _____________________________________

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__ Friend(s) _____________________________________

__ Other _____________________________________

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(This section to be completed by West Georgia Obstetrics and Gynecology, P.C.,)

After a good faith attempt to obtain an acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

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