ASSOCIATES IN WOMEN'S HEALTH CARE

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy of
Name of Patient (please print)

Associates in Women's Health Care Notice of Privacy Practices.

_____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date Print Name of Legal Representative/Relationship

FOR CLINIC USE ONLY:

Associates in Women's Health Care made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices. However, such acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ❑ Other reason (describe below): _____

_____ _____
Signature of Employee Completing Form Date

Effective date April 14, 2003