Notice of Privacy Acknowledgement

OB/GYN Associates of Miami, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I Also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledgement receipt of Notice Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____