GynoFitMD
Women's Health & Medical Weight Loss Expert

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and 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 health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that GynoFitMD ("Practice") has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

3345 S. Val Vista Drive, Ste. 103
Gilbert, AZ 85297
(480) 769-7719

Patient Name: _____ Signature: _____ Date: _____
(Print)

Relationship to Patient: _____ Signature: _____ Date: _____
(if not signed by patient)

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

- ☐ Patient or guardian refused to sign
- ☐ Emergency situation
- ☐ Other: _____