PATIENT ACKNOWELDGEMENT OF NOTICE OF PRIVACY PRACTICE

Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I received a copy of the Notice of Privacy Practices of Tifton Woman's Center, P.C. on the date indicated below.

I understand if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Tifton Woman's Center, P.C.

I also understand that if I wish to receive additional; copies of this notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

Tifton Woman's Center, P.C.
Practice Administrator
1806 Lee Avenue
Tifton, GA 31794
Phone: (229) 386-1528
Fax: (229) 382-2958

_____ _____

Signature of Patient **Date**

<u>This space is used by the practice only:</u>

Date of acknowledgment: _____

Reason denied by patient: _____

Name of person reviewing denial: _____

Date: _____

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