Atlanta Women's Center
235 West Wieuca Road, Atlanta, GA 30342 (404) 257-0057

Notice of Privacy Practices
Acknowledgment and Consent

The Health Insurance Portability & Accountability Act (HIPAA) and state law give you certain rights to privacy regarding your protected health information (PHI). At the Atlanta Women's Center, we understand that your medical information is private and confidential. Our Notice of Privacy Practices gives a complete description of the ways we may use and disclosure of your health information. Please review this Notice of Privacy Practices notice carefully. It is located just outside the receptionist's window. You may also request a copy to take with you, or access it on our website at www.atlantawomenscenter.com. If you have any questions or would like further information about HIPAA, please ask one of our staff members. We are more than willing to "talk HIPAA!"

Once you have reviewed our Notice of Privacy Practices and had your questions about it answered to your satisfaction, please sign the following Acknowledgement.

We also request, but do not require, that you provide us written consent to the disclosures permitted by HIPAA.

Acknowledgment

I certify that I have been offered a copy of Atlanta Women's Center Privacy Notice, given an opportunity to read it, and had my questions about it answered to my satisfaction.

I understand that Atlanta Women's Center reserves the right to amend its privacy policies, and that I can ask for a copy of the current Privacy Notice at any time.

I understand that I have the right to request restrictions on how Atlanta Women's Center uses and discloses my PHI, but that Atlanta Women's Center is not required to agree to my request.

Patient Name: _____ Date: _____

Patient Signature: _____

Consent to HIPAA-Permitted Uses and Disclosures of Information

I consent to Atlanta Women's Center using and disclosing my PHI as needed:

- For my treatment – to any physician or other health care providers or facilities that needs the information for my continued care;

- For obtaining payment for my treatment – to determine and obtain coverage from a health insurance company and/or a medical assistance fund if I seek assistance from such third party to pay for some or all of my treatment;

- For this facility's healthcare operations – to operate more efficiently, and to assess and improve quality of care.

I understand that I have the right to revoke this consent, in writing, at any time, but that the revocation will apply only to uses and disclosures of my PHI after the revocation.

Patient Name: _____ Date: _____

Patient Signature: _____