MANHATTAN WOMEN'S HEALTH
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and 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; and conduct normal healthcare operations such as quality assessments and physician certifications.

I have received a copy of Manhattan Women's Health's *Notice of Privacy Practices for Protected Health Information*, which contains a more complete description of how medical information about me may be used and disclosed, and how I can get access to this information.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so.

Date:	Initials:	Reason: