Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review a copy of Atlanta Women's Health Group, P.C. ("AWHG") Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify AWHG, in writing, of any request for restrictions in the use or disclosure of my protected health information ("PHI"). I understand AWHG has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.awhg.org. AWHG will provide me with a copy of its most recent Notice upon my request.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____ _____

Date

Name(s) of others authorized to discuss or receive my PHI:

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