Gynecologic Specialists of Brevard, LLC
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PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name:_____

Date of Birth:_____ Notice Version (date): September 23, 2013

Acknowledgement of receipt of Privacy Practices Notice.

I,_____ acknowledge that I have received a Privacy Practices Notice from: Gynecologic Specialists of Brevard, LLC

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Notice has previously been distributed by another location in our OHCA (except of physicians):

List location that distributed the Joint Notice:_____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

IF NOT SIGNED: (Good Faith effort to obtain acknowledgement of receipt.)

Describe your good faith effort to obtain the individual's signature on this form:_____

PLEASE LIST INDIVIDUAL'S WHO MAY ACCESS YOUR MEDICAL/FINANCIAL INFORMATION:

_____

_____

SIGNATURE (Practice Representative)
I attest that the above information is correct.

Signature:_____ Date:_____

Print Name:_____ Title:_____

HIPPAA Form #20 Include this acknowledgement form in the individual's records.

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