ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have had a chance to review
(Patientôs printed name)

(and keep, if desired) the Notice of Privacy Practices of Sunflower Ob-Gyn, PA. I understand that the practice has the right and / or obligation to release my information in certain situations. Additionally, my medical information may be released to individuals I specifically authorize.

- My medical information
  may be released to: _____
- I request that the practice
  NOT release my information to: _____

_____ _____
Patient's Signature Today's Date:

If signature is not that of the patient, indicate the relationship of the person signing for the patient. (Parent, Guardian, etc.) _____

If the patient's personal representative does not sign, indicate the reasons why the patient's signature could not be obtained. _____

_____ _____
Acknowledged by Practice Staff Member Today's Date

'Of Note: Due to this HIPPA law, we are unable to release information about our patient's whereabouts. If you expect a guest to join you today during your visit with us, please make sure that he or she is with you when you are called back for your appointment.