ATLANTA UROGYNECOLOGY ASSOCIATES

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that Atlanta Urogynecology Associates has a Privacy Policy in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Atlanta Urogynecology Associates, I understand and acknowledge the following:

1. Atlanta Urogynecology has a privacy policy in effect in their offices.
2. Atlanta Urogynecology has made this policy available to me for review, if requested.
3. Atlanta Urogynecology has made me aware that I am entitled to a copy of this Privacy Policy.

This practice participates in research studies. Your chart may be reviewed by the staff at Atlanta Urogynecology Associates to gather data so that we can continue to provide our excellent quality of care. **You will not be identified**. Atlanta Urogynecology follows all HIPAA regulations.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Atlanta Urogynecology and have read and understand this acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

________ NO, I do not want a copy, but acknowledge that the Privacy Policy exists.

________ YES, I do want a copy of the Privacy Policy.

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Patient Name	Patient Signature	Date