



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have been made aware of Georgia Fibroids' **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Georgia Fibroids' healthcare operations. The Notice also describes my rights as well as Georgia Fibroids' duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of each facility and on Georgia Fibroids' website at:

www.GAFibroids.com

I may request that a copy be mailed to me by calling 678-915-2000.

Georgia Fibroids physicians reserved the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at a time of my next appointment, or by accessing Georgia Fibroids' website listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

TODAY'S DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY