NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

Fertility & Women's Health Center of Louisiana
4630 Ambassador Caffery Suite 206
Lafayette, Louisiana 70508

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations.

I have received Fertility & Women's Health Center of Louisiana's Notice of Privacy Policy which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Policy from time to time and that I may contact this facility at any time at the address above or the website (fwhcla.com) to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: