The Women's Specialists of Fayette
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that the Women's Specialists of Fayette has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1196 (HIPAA).

As a patient of the Women's Specialists of Fayette, I understand and acknowledge the following:
1. WSF has a privacy policy in effect in their office
2. WSF has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. WSF has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file

Upon review of the above statements, please sign the bottom acknowledging that you have been advised of the privacy policy implemented by WSF and have read and understood the acknowledgement 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 the Privacy Policy exists.
_Yes, I do want a copy of the Privacy Policy.

_____ _____ _____
Patient Name Patient/Guardian Signature Date of Birth

Patient Agreement for Communication

I understand that as part of my healthcare, WSF will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize WSF to contact me in the following ways (check those which you authorize):
___Home Phone___voicemail ok
___Cell Phone ___voicemail ok
___work Phone___voicemail ok

I understand that The Women's Specialists of Fayette will use the minimum necessary information needed when communicating with me directly. I understand that I may revoke or modify this agreement at any time, Any revocation or change will not apply to past communications.

I further authorize the Women's Specialists of Fayette to discuss matters related to my condition/care with the following:

_____ _____
Name (please print) Relationship to patient

_____ _____
Name (please print) Relationship to patient

_____ _____
Signature (guardian if patient is a minor) Date