TIRPACK GYNECOLOGY
Jill Tirpack, M.D.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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 multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Effective April 14, 2003 (due to federal guidelines under HIPPA) we are now required to have a release form signed by patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc;) that we may discuss your medical or financial information with:

NAME RELATIONSHIP PHONE NUMBER

1.____

2.____

3.____

May we leave medical information on your "home" answering machine? Yes _________ No_________

____

Signature of Patient/Parent Date

OR

If you do not want any medical or financial information discussed with anyone other than yourself please sign here:

____

Signature of Patient/Parent Date

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.

OFFICE USE ONLY

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

Date:	Initials:	Reason: