



Castillo Walters OB/GYN
A Division of Atlanta Women's Health Group, P.C.

***Acknowledgment of Receipt of Notice
Privacy Practices***

PATIENTS NAME: _____ ACCT# _____

- ❖ I understand that I can request a restriction on how my health information is use for disclosed to carry treatment or health care operations. However, there may be times when Atlanta Women's Health Group, P.C., is not able to honor my requested restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.

- ❖ I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment, obtaining payment, or to conduct necessary health care operations, and authorize direct payment of medical insurance benefits to Atlanta Women's Health Group, P.C., for services performed. I also understand and agree that I am responsible for payment of all valid charges not paid by my medical insurance.

- ❖ I accept that there is no guarantee of protection of my medical records from a court ordered release. In the event of legal proceedings involving patient care, I understand the contents of my file must be made available to legal counsel representing the practice and professional employee.

- ❖ I have received a copy of Atlanta Women's Health Group's, Notice of Privacy Practices on the date listed below, and I have been advised that I will be notified of any changes at future office visits. I may obtain a current copy by visiting the Website at www.awhg.org

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Date