State *of* Franklin
OB/GYN Specialists
A division of State of Franklin Healthcare

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Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected medical information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

1. _____ **Relationship:** _____
2. _____ **Relationship:** _____
3. _____ **Relationship:** _____
4. _____ **Relationship:** _____
5. _____ **Relationship:** _____

By signing below, I agree to the fore mentioned statements.

_____ _____
Patient (or Guardian and relationship) **Date**

_____ _____
Practice Representative **Date**

_____ _____
Patient Name **DOB**

_____
Chart Number