

**ATHENS WOMEN'S CLINIC, P.C.**  
**817 COOK DRIVE**  
**ATHENS, TN 37303**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I have been given the opportunity to review the Notice of Privacy Practice s 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 health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

	NAME	RELATIONSHIP
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

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

\_\_\_\_\_  
**Patient Name Printed**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature(Patient must sign regardless of age)**

\_\_\_\_\_  
**Account Number/Chart Number**