*ADVANCED CARE FOR WOMEN*

*Manuel R. Quintana, M.D., FACOG* *Denis A. Perez, M.D., FACOG*

*Board Certified OB/GYN*

*Andrea L. Williams, MSN, NP-C*

**ACKNOWLEDGMENT OF RECEIPT OF**
**ADVANCED CARE FOR WOMEN**
**HIPPA NOTICE OF PRIVACY PRACTICES**

Advanced Care for Women has offered me a copy of the HIPPA Notice of Privacy Practices ("Notice") and I am

_______ accepting a copy at this time.

_______ refusing a copy, but I am aware that I can request a copy at any time.

The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by notifying the Privacy Officer at Advanced Care for Women.

Signature: ______________________________

Print Name: ______________________________

Date: ______________________________

*800 Century Medical Drive • Suite B • Titusville, Florida 32796*
*(321) 383-2122 • (321) 383-4119 Fax*