Renée C. Smith M.D., FACOG
Wise Obstetrics & Gynecology, P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name ____________________________________

Date of Birth ____________________________________

I acknowledge that Wise Obstetrics & Gynecology offered to provide me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

______________________________	______________________
Patient Signature	Date
______________________________	______________________
Personal Representative Signature (if applicable)	Relationship to Patient