ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY

FERTILITY INSTITUTE OF HAWAII

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Advanced Reproductive Medicine & Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii's ***Notice of Privacy Policies***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Name:_____

_____

Signature of patient, parent, or representative Relationship

_____

Date

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**Internal Use Only:**

If a patient or the patient's representative refuses to sign the Acknowledgement of Receipt of Notice, please document the date and time the notice was resented to the patient and sign below.

Presented on (Date and Time):

_____

By: (Name and Title):

_____