Theodore V. Benderev, M.D.
Kym A. Kanaly, M.D.
Patricia A. Wallace, M.D.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of the Incontinence & Pelvic Support Institute, Inc., and Patricia A. Wallace, M.D., Inc.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to conduct, plan and direct my treatment among the multiple health care providers who may be involved in that treatment directly and indirectly, to obtain payment for services provided and conduct normal health care operations.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949/364-4400.

I acknowledge receipt of the ***Notice of Privacy Practices*** of the Incontinence & Pelvic Support Institute, Inc., and Patricia A. Wallace, M.D., Inc.

Signature: ______________________________________ Date: ______________________
(patient/conservator/parent/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: ________________________________ Date: ________________

____ Individual refused to sign notice

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify): ____

____

____