women's center for health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date of Birth _____

I acknowledge that I have received a Notice of Privacy Practices on the date below on behalf of Women's Center for Health. I understand that the Notice describes the uses and disclosures of my protected health information by Women's Center for Health and informs me of my rights with respect to my protected health information.

_____ _____

Signature of patient / personal or legal representative

Printed name of patient / personal representative

_____

Date

If personal or legal representative, indicate relationship _____

I authorize Women's Center for Health to leave a message on my voicemail regarding confidential health information:

Approved phone number (____) _____

Name of the person(s) and relationship that you are authorizing Women's Center for Health to disclose your personal health information to:

Name _____ Contact # (____) _____

Relationship ☐ Spouse ☐ Child ☐ Guardian ☐ Friend ☐ Other _____

Name _____ Contact # (____) _____

Relationship ☐ Spouse ☐ Child ☐ Guardian ☐ Friend ☐ Other _____

Describe in detail the information you are authorizing to be disclosed to the above named person(s):

_____

_____

_____

_____

This authorization will be revoked upon your request

Updated above info Patient Initials	Date	Updated above info Patient Initials	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____