Women's Center for Health Privacy Practices and Confidential Communication Form

I, ____, hereby request Women's Center for Health
(Name of Patient or Authorized Agent)

to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at ___________________________

Leave messages on answering machine: ____ Yes ____ No

Mail: Contact me at the following address: ___________________________________

____

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

____Spouse ____ Child
____ Guardian ____ Friend
____ Other

_________________________ Relationship (check above) (_____) ____-________
Name Contact Number

____Spouse ____ Child
____ Guardian ____ Friend
____ Other

_________________________ Relationship (check above) (_____) ____-________
Name Contact Number

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

____

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Women's Center for Health may use and disclose my protected health information. I understand that the Women's Center for Health has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me in the offices of the Women's Center for Health, or on the website www.womenscenterforhealth.org.
This request may be changed or revoked by filing a new request or revoking this one in writing.

_____ Please initial to confirm the receipt of WCH Privacy Notice and Data Sharing Agreement

Signed: ____ Date: _____________________

If you are not the patient, please specify your relationship to the patient: ________________________