



Patient Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this practice's Notice of Privacy Practices (NPP). This practice reserves the right to change the terms of this Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain a copy of the current NPP on request.

Signature _____ Date: _____

Relationship to patient (if signed by a personal representative of patient) _____

I authorize the practice to discuss my health care with the following person(s): Please circle.

No One Husband Mother Father Child Other

Name and Relationship must be written in order for us to comply with NPP.

I authorize Women's Health Care to leave health care information on my:

Cell Phone Home Phone Neither