WOMEN'S HEALTH SPECIALISTS, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices gives you information about how we use and disclose medical information about you. A copy of our Notice of Privacy Practices will be posted in our office and will appear on our website.

By signing this form, you acknowledge that you are entitled to request a copy of our Notice of Privacy Practices at any time.

Printed name of Patient: ____

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Signature of Patient or Personal Representative Relationship

____

Date

Please indicate how you would like us to communicate information regarding your appointments and normal results (if other than directly to the patient):

[ ] message on answering machine
[ ] e-mail address:_______________________________________
[ ] to the following individuals:
Name_________________________Relationship _______________
Name_________________________Relationship _______________
Name_________________________Relationship_______________

***** *It is the patient's responsibility to revise and/or delete any of the information listed above.* *****

FOR INTERNAL USE ONLY:

If not signed, reason:

[ ] Patient refused to sign _
[ ] Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments ____

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____ ____________________

Name of Employee Date