WOMEN'S HEALTH SERVICES

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Women's Health Services reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.womenshealthservices.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at the appointment

______________________________	______________
Patient's Printed Name	Date of Birth
______________________________	______________
Patient's Legal Representative's Signature	Date
______________________________	
Relationship to Patient	
______________________________	______________
Witness	Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Women's Health Services to share my protected health information with:

______________________________	______________
Name	Relationship
______________________________	______________
Name	Relationship
______________________________	______________
Name	Relationship