

Acknowledgment of Receipt of Privacy Notice

Caring for Women P.C.

By signing below, I acknowledge that I have been provided with a copy of Caring for Women P.C. Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Caring for Women P.C. and how I may obtain access and control this information.

* _____
(Signature of Patient or Guardian)

* _____
(Print Patient name or Guardian)

* _____
(Date)

* _____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. _____

2. _____

3. _____

May we leave a message on an answering machine? YES NO

Preferred method of contact:

Home# _____

Cell# _____

Work# _____