

Patient Name: _____ Chart # _____

**Women's Health Associates
Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed and/or received a copy of the Notice of Privacy Practices for Women's Health Associates and authorize the release of my Protected Health Information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

Women's Health Associates has my permission to leave appointment and medical information with:

Please initial each method that you approve:

- _____ Anyone in my home
- _____ Home answering machine
- _____ Work answering machine/voicemail
- _____ Cell phone (voicemail)
- _____ Spouse/Partner
- _____ **Patient ONLY**
- _____ Other: _____
Please be specific

Print Patient Name

Patient Signature

Date