Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________________ Date: __________________

I give Independence Women's Clinic permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services. *If you decline to give such permission, leave the following blank.*

Name/Relationship ____

Name/Relationship ____

Name/Relationship ____

I give Independence Women's Clinic permission to leave a message with the person who answers the telephone or a voice-mail message at the most current telephone number on file concerning appointment reminders or requesting that I contact my health care provider. *If you decline such permission, do not list any telephone number below.*

Telephone Number(s): ____

I give Independence Women's Clinic permission to contact me at the following telephone number or send a message to the most current e-mail address on file to notify me of any breach of my protected health information. *If you decline such permission, do not list any telephone number or e-mail address below:*

Telephone Numbers(s): ____

E-mail Address: ____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____________________________________ have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

____

(Signature of patient or parent/legal guardian/legal responsible person)

____ _________________________

(Relationship to Patient) *(Date)*

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❏ Individual/representative refused to sign form
- ❏ An emergency situation prevented us from obtaining acknowledgement
- ❏ Other (please specify) ____