



Acknowledgment of Receipt of Privacy Practices

I hereby acknowledge that I have been given an opportunity to review the privacy practice at Women's Physicians Associates. I understand that I may obtain a copy of the Notice of Privacy at my request.

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

List all individuals who may receive medical information from our facility

I understand that any person who is not a legal guardian whose name does not appear on the above list will not be given access to any medical information without written permission

Patient's full name (print)

Signature of patient's or legal representative

Date

Signature of staff receiving acknowledgement

Date