Women's Health Medical Group, P.A.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name of Patient or Personal Representative	Date	Date of Birth
Signature of Patient or Personal Representative	Date	
Printed Name of Patient or Personal Representative	Date	Date of Birth
Description of Personal Representative's Authority	Date	Date of Birth

I, _____ give authorization to Women's Health Medical Group to release any information regarding my account/medical records to:

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

Signed	Date	Witness	Date

I consent and authorize the release of any test results on my voice mail at my
___home ___cell ___work number.