

# 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.