Associates In Women's Care, P.C.

Notice of Privacy Practices – Patient Acknowledgement

We at Associates In Women's Care, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following:

Patient Name (please print) _____

Date of Birth _____

Home Phone _____

May we leave a detailed voice mail message for you here? Y N

Work Phone _____

May we leave a detailed voice mail message for you here? Y N

Cell Phone _____

May we leave a detailed voice mail message for you here? Y N

May we speak to someone else regarding your medical care? Y N

Name of person(s):	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been made aware of the privacy policies of Associates In Women's Care, P.C., and have received (or reviewed or been given the option to receive) a copy of the Notice of Privacy Practices.

Acknowledged: _____ Date: _____