

WOMEN'S CENTER at PRESTONWOOD

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

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This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

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Name of Patient (Print)

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Signature of Patient

Date of Signature

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Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient

**Request for Confidential Communication of Your Protected Health Information**

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls?      Yes    No    N/A

May we leave **messages** on a voice mail at work?      Yes    No    N/A

May we discuss your **appointments/treatment** with your spouse?    Yes    No    N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian?      Yes    No    N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children?      Yes    No    N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

12/06