

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

We keep a record of the health care services we provide you. You may ask to see, copy or correct your medical records. We will not disclose your medical records to others unless you direct us to or unless the law authorizes and compels us to do so. You can get more information about this by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access that information. You can request a printed copy of this detailed Notification of Privacy Practices for our clinic, or view it online at www.whconnection.com under “New Patient Registration”.

By my signature below, I acknowledge that I have been informed of the privacy practices of the Women’s Health Connection, PS.

Print Name Date

Signature

I _____, give Women’s Health Connection the right to release my health information to the following recipients:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient or Guardian Signature Date