

Associates for WOMEN'S MEDICINE

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Acknowledgement: Receipt of Associates for Women's Medicine Notice of Privacy Practices

I acknowledge that I received the Notice of Privacy Practices Associates for Women's Medicine.

Name of patient

Signature of patient (or patient's personal representative) Date of receipt

Signature of legal guardian Date of receipt

Restricted Communication Request

I hereby request that test results may only be left on the following phone number and voice mail system(s).

Please list above all phone numbers where we may contact you and/or leave test results on your voice mail system.

Designation of Personal Representative

In addition to myself, I designate the following individual(s) as my personal representative and grant Associates for Women's Medicine permission to disclose (written and verbal) my Protected Health information with the individual(s) named below.

Name of representative Relationship to patient

Name of representative Relationship to patient

Name of representative Relationship to patient

I understand that I may revoke this authorization at any time.

I choose not to designate any other person as my personal representative

Signature of patient Date of receipt