Conway Women's Health Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We, Conway Women's Health Center ("CWHC"), are legally required to give you a copy of our *Notice of Privacy Practices*. By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of CWHC which provides information on how we may use and disclose your protected health information. We encourage you to review it carefully.

I, _____, have received a copy of the *Notice of Privacy Practices* of CWHC and have had an opportunity to review it and ask any questions concerning it before signing this acknowledgement. I hereby authorize and give consent to all the uses and disclosures in CWHC's *Notice of Privacy Practices*.

_____ _____
Patient – Printed Name Patient – Signature

_____ _____
Date Personal Representative of Patient

----------For Office Use Only----------

CWHC attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____
_____
_____
_____

_____ _____ _____
Signature of Staff Member Printed Name of Staff Member Date