

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WOMEN'S CARE MEDICAL GROUP

650-366-5594

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

SIGNED: _____ DATE: _____

Print Name: _____

I hereby authorize Women's Care Medical Group and their agents to leave any message regarding my medical status/condition at the following phone numbers

Updated Phone Number(s)

Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____
Date ___/___/___	Initial _____	_____	_____

If not signed by the patient, please indicate:

- Relationship: _____ parent or guardian of minor patient
 _____ guardian or conservator of an incompetent patient
 _____ beneficiary or personal representative of deceased patient