



**Written Acknowledgment of Receipt of the Notice of Privacy Practices**

\_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Patient Name**  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Caring for Women's Health can disclose to the following individuals my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Caring or Women's Health may also use or disclose this information as necessary to notify the following individuals of my general condition, location, or death.

1. Spouse \_\_\_\_\_
2. Significant Other: \_\_\_\_\_
3. Any Specific Person(s): \_\_\_\_\_
4. I may be contacted my mail concerning my heath: Yes or No (circle one)
5. I may be contacted via voice mail, or answering machine: Yes or No (circle one)
6. I may be contacted via email: Yes or No (circle one)

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Healthcare Representative**

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
Date