Associates for Women's Medicine

Receipt of HIPAA Notice of Privacy Practices
Written Acknowledgement Form

I, _____ , have received a copy of Associates for Women's Medicine HIPAA Notice of Privacy Practices.
Patient Name

_____
Date of Birth

Authorization to Discuss Health Information

I authorize Associates For Women's Medicine to discuss my health information with

_____ (Name of person)	_____ Relationship
_____ (Name of person)	_____ Relationship
_____ (Name of person)	_____ Relationship
_____ (Name of person)	_____ Relationship

☐ I decline to give anyone permission to have access to my medical information:

_____ Signature of Patient

_____ Date

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