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
Patient Name
HIPAA Notice of Privacy Practices.

_____
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 |

_____ _____
Signature of Patient Date

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