ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
COMMUNICATIONS CONSENT

I acknowledge that I have received or have been offered a copy of the *Notice of Privacy Practices*

_____ ____/____/____ ____/____/____
Patient or Personal Representative Signature Patient's Date of Birth Today's Date
(Please circle relationship: ***Self Parent Guardian Spouse***)

TELEPHONE COMMUNICATION

1. Primary Telephone #:	2. Secondary Telephone #:	3. Addition Phone #:
(_____) -_____ -_____	(____) -_____-_____	(____)-_____-_____
(Please circle one: cell home work spouse other)	(Please circle one: cell home work spouse other)	(Please circle one: cell home work spouse other)
___ May leave detailed message. ___ May only leave a call back number.	___ May leave detailed message. ___ May only leave a call back number.	___ May leave detailed message. ___ May only leave a call back number.

I give permission for Women's Health Care to discuss my medical information with the following:
(if you wish for us to speak to **NO ONE** please write "No on" on the first line)

Name: _____ **Relationship:** _____
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

Name: _____ **Relationship**: _____
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

Name: _____ **Relationship:** _____
(**Please circle *all* that apply**: appointment information / test&lab results / billing information)

WRITTEN COMMUNICATION
(Please circle yes or no for each of the questions below)

Please expect to get billing statements, test results, and other medical information mailed to the address that is most current, provided by the patient, that is on file

Yes No Ok to fax to this number (_____) _____ - _____

Yes No Patient information or medical records may be faxed to other health care providers, hospitals, or insurance if necessary.

I agree this it is my responsibility to inform Women's Health Care of Morgantown, in writing, if I wish to change any of the above information for future disclosure.

_____ _____ ____/____/____
Print name Patient Signature Today's Date