Patient Account #: _____

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review a copy of Atlanta Women's Health Group, P.C. ("AWHG") Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify AWHG, in writing, of any request for restrictions in the use or disclosure of my protected health information ("PHI"). I understand AWHG has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.awhg.org. AWHG will provide me with a copy of its most recent Notice upon request.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Others authorized to discuss or receive my PHI:

1. Name: _____ Contact Info: _____
2. Name: _____ Contact Info: _____
3. Name: _____ Contact Info: _____
4. Name: _____ Contact Info: _____

Which method of contacting you is preferred?

☐ Phone: _____ ☐ Email: _____

(Please note that both methods may be used to contact you.)

When we are calling with medical information or results, do you authorize our office to leave a detailed message on your voicemail?

Initial either: _____ YES _____ NO