Acknowledgement of Receipt of Notice of Privacy Practices

San Francisco Women's Healthcare, Inc.
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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices in each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

parent or guardian of minor patient
guardian or conservator of an incompetent patient
beneficiary or personal representative of deceased patient

Name of Patient: _____