# ALL FOR WOMEN HEALTHCARE, S.C.
## RECEIPT OF NOTICE OF PRIVACY PRACTICES
## WRITTEN ACKNOWLEDGEMENT FORM

I, _____, hereby acknowledge that I have read a copy
(print name)
of **ALL FOR WOMEN HEALTHCARE, S.C.** "HIPAA Notice of Privacy Practices" in their office.

_____ _____
Patient Signature Date

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

**I authorize All For Women Healthcare, S.C. to contact me at the following places:**

| | | |
|---|---|---|
| Home telephone | Yes ☐ | No ☐ |
| Cell phone/voice mail | Yes ☐ | No ☐ |
| Work telephone | Yes ☐ | No ☐ |
| Answering machine | Yes ☐ | No ☐ |
| Cell phone number | Yes ☐ | No ☐ |

Please list names of people with whom we may discuss your medical care:

Spouse Name _____ Yes ☐ No ☐

Parent Name _____ Yes ☐ No ☐

Other Name _____ Yes ☐ No ☐

Please list names of people with whom we may discuss your financial information.

_____

_____

_____

_____ _____
Signature of Patient/Guardian Date

***THIS FORM IS TO BE COMPLETED ANNUALLY***