A Woman's Place, LLC

- *ACKNOWLEDGEMENT OF PRIVACY PRACTICES*

I acknowledge that the Notice of Privacy Practices at A Woman's Place, LLC was made availableto me. I understand that the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of my protected health information (PHI).

_____ (Print Patient Name)

- *EMERGENCY CONTACT* *(No medical information will be given to this person)*

Name	Relationship	DOB	Phone number

- *PATIENT RECORD OF DISCLOSURES*

I consent to A Woman's Place, LLC to use and disclosure of my PHI to carry out treatment, payment and healthcare options.

_____ (Print Patient Name)

To make it more efficient for A Woman's Place to reach me, I wish to be contacted by the following **ONE** phone number for **ALL** medical and administrative purposes. This also allows any staff member of A Woman's Place to leave me a detailed message if I am unavailable.

Please check the box in front of your choice: ☐ HOME ☐ WORK ☐ CELL

Phone Number: _____

I give my permission to release my medical information to the following family member(s), agent(s), or office(s):

Name	Relationship	DOB	Phone number
Name	Relationship	DOB	Phone number
Name	Relationship	DOB	Phone number

☐ Please check the box if you give NO ONE permission to access your medical information.

I agree to update all contact information when changes occur.

_____ _____

Patient Signature Date