Women's Care

Year: 2025

RECEIPT OF HIPAA NOTICE OF PRIVACY ACKNOWLEDGMENT

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. **Please read carefully.**

Women's care, Inc. is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of the HIPAA notice which describes the health information privacy practices of our office, our medical staff and affiliated healthcare providers that jointly perform payment activities and business operation with our office. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care service.

I certify that I have seen the Notice of HIPAA Privacy Policies that is posted in the lobby. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information that might occur in my treatment and payment of my bills or in the performance of Women's Care Inc.'s health care operations. I authorize payment of medical and/or surgical benefits to Women's Care Inc. (including Medicare, other government sponsored programs, private insurance and any other insurance plan). I understand that I am financially responsible for medical charges, whether or not paid by my insurance. Women's Care is not responsible for any claimed errors in payment not exceeding the actual charge. The Notice of HIPAA Privacy Policies also describes my rights and Women's Care Inc.'s duties with respect to my protected health information. I may obtain a revised Notice of HIPAA Privacy Practice by calling the office or asking for one at the time of my next appointment.

Printed Name: _____ Date of Birth: _____

Race: _____*Required by Healthcare/Meaningful Use legislation*(lab purposes)

Patient Signature: _____ Todays Date: _____

IF THE PATIENT IS UNABLE TO SIGN:

Health Care Agent/Guardian/Relative Signature

_____Patient is unable to sign due to medical reasons
_____Patient refuses to sign
_____Other (please explain) _____

(TURN OVER)

This acknowledgment form will become part of your permanent record.

MEDICAL INFORMATION RELEASE FORM

NAME: _____ DOB: _____
Print

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION TO ANY OTHER PARTY AS AUTHORIZED BY THE PATIENT (*family member etc.*)

This release of information will remain in effect until terminated by the patient in writing.

_____ INFORMATION IS **NOT** TO BE RELEASED TO ANYONE

_____ I **authorize** the release of information including diagnosis, examination of records, test results rendered to me and claims information. This information may be released to the person(s) listed below:

NAME	PHONE	RELATIONSHIP

IN CASE OF EMERGENCY CONTACT: _____
Print

CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

MESSAGING PREFERENCES

Please call: _____my home _____my work _____my cell _____my email

Please select one
If unable to reach me: _____ you may leave a detailed message
_____ you may leave a message to return your call

Signed: _____ Date: _____

Witness: _____ Date: _____

(TURN OVER)

This acknowledgment form will become part of your permanent record.