ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **DOB**: _____

I hereby authorize Alpine Women's Center to disclose my Protected Health Information (PHI) to the following persons:

Name: _____
Name: _____
Name: _____
Name: _____

- Disclosure may occur in the form of phone conversations, phone messages, mail, or in person. I understand by signing this authorization, above information may include alcohol, drug abuse, mental, and/or other highly confidential information health records obtained in the course of my diagnosis and treatment.
- I give permission to this office to leave phone messages at any phone number I provide this office.
  ☐ Please check box if ok to leave a detailed voicemail message
- I understand that I may revoke this authorization at any time by notifying Alpine Women's Center in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that once the information described herein is disclosed, it may be re-disclosed by recipient and no longer subject to the privacy protections.

Patient Signature: _____ **Expiration Date**: ___/____/_____

(If left blank, authorization expires twelve (12) months from the date on which it was signed)

Witness: _____ **Date**: _____/_____/_____