Patient Account# _____

Acknowledgement of Receipt of Notice of Privacy Practices

Women's Health Specialist of Dallas, P.A. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for
Women's Health Specialist of Dallas, P.A.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

Secure Phone Option:
Is there a phone number on which personal health information could be left on your message recording in the event you are not available when we call? **Y** **N**

If 'Yes', what is the number? _____

Expanded Authorization Option:
Please list any persons you would like to authorize to have access to your billing, appointment or health information* such as your spouse, caretaker, or other family member:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

*With the exclusion of information that is protected under State and Federal law.

If Patient is a minor:

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Please not that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.