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The Wright Center for Women's Health
Personalized Luxury Healthcare

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Receipt Notice of Privacy Practice Form

I,_____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Pricavy Practice provides detailed information about how the practice my use and disclose my confidential information. A copy of the Notice is available in the reception area.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notices will be provided to me or made available via a posting in the reception area of The Wright Center for Women's Health.

Signature:_____ Date:_____

If you are not the patient, please specify your relationship to the patient:_____

Sharing of Health Information with Other Providers

I understand my medical information may be shared with providers not affiliated with The Wright Center for Wpmen's Health who may care for me after my hospital stay, or outpatient visit. I understand that this medical information may include sensitive information relating to sexually transmitted diseases, AIDS/HIV, Alcohol and drug abuse treatment, behavioral or mental health records, including genetic information. Please check one of the following boxes:

□ I authorize The Wright Center for Women's Health to release my medical information to providers who are not affiliated with The Wright Center for Women's Health for continuation of care.

□ I do NOT authorize The Wright Center for Women's Health to release my medical information to providers who are not affiliated with The Wright Center for Women's Health for continuation of care.

Signature:_____ Date:_____

Communication Choices

Verbal – By completing and signing this form, I authorize The Wright Center for Women's Health to contact me and/or leave messages regarding medical information and/or appointments using the following contact information for the patient identified above. I understand that this document will remain in effect unless I change or revoke it in writing.

Please indicate your preferred phone number:

Primary Phone Number:_____ □ Cellular Phone □ Home/Landline □ Work

□ I prefer NOT to receive appointment reminders. □ Leave only a message for me to call back.

My medical information may be shared with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

E-mail – My email address is _____ and I authorize The Wright Center for Women's Health to contact me using their confidential email system with appointment notifications as well as any monthly statements and promotions that may arise.

Signature:_____ Date:_____