Pacific Women's Center
Physicians and Surgeons

Medical Practice
Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I am aware of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Pacific Women's Center's health care operations. The Notice of Privacy Practices also describes my rights and Pacific Women's Center's health care operations. The Notice also describes my rights and Pacific Women's Center's duties with respect to my protected health information. **The Notice of Privacy Practice is posted in the front lobby and on Pacific Women's Center's website at *http://www.pacificwomenscenter.com/*.**

I further certify that I am aware of the Electronic Data Sharing provision which I have been given the option to Opt Out of and understand that by signing this acknowledgement I am agreeing to Pacific Women's Center LLC's participation to share my medical records with Facilities and Providers that will mutually participate in my healthcare.

Pacific Women's Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by mail, asking for one at the time of my next appointment, or accessing Pacific Women's Center's website.

______________________________________	____________________
Signature of Patient	Date
______________________________________	____________________
Print Patient Name	DOB

Or

______________________________________	____
Signature of Personal Representative	Description of Personal Representative's Authority
______________________________________	____________________
Print Representative's Name	Date