Year: 2024

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 received a copy of Notice of HIPAA Privacy Policies. 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. The Notice of HIPAA Privacy Policies is posted in the reception area. Women's Care reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of HIPAA Privacy Policies by calling the office, asking for one at the time of my next appointment, or on our website at wcareinc.com.

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)____

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

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)