The Womens Centre

Patient Name: _____ **Patient #:** _____

Social Security# (last 4 digits): _____ **Date of Birth:** _____

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

_____

Please provide an email address that this office may communicate health information to you with:

_____

Please provide a cell phone or home number that we may leave a message or text health information to:

_____

Please provide us with the name and number of your emergency contact:

_____

Please provide us with the name(s) and phone number(s) that we may share the following information:

(Check all that apply)

☐ **Appointments** ☐ **Treatments/Test Results/Prescriptions** ☐ **Billing**

_____ _____

Name *Phone Number*

_____ _____

Name *Phone Number*

I acknowledge that everything above is accurate.

_____ _____ _____

Signature *Printed Name* *Date*

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices."

_____ _____ _____

Signature *Printed Name* *Date*

_____ _____

Relationship if Patient Representative *Physician Office Representative*

_____