Acknowledgment of Receipt of Privacy Notice

North Scottsdale Women's Care P.C.

By signing below, I acknowledge that I have been provided with a copy of North Scottsdale Women's Care P.C. Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by North Scottsdale Women's Care P.C. and how I may obtain access and control this information.

* ____
(Signature of Patient or Guardian)

* ____
(Print Patient name or Guardian)

* ____
(Date)

* ____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. ____

2. ____

3. ____

May we leave a message on an answering machine? YES NO

Circle preferred method of contact:

Home#____

Cell# ____

Work# ____

Email:____