Westside women's care

A Partnership of Professional Corporations

Gynecology • Infertility • Obstetrics

Acknowledgement of Notice of Privacy Practices

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of patient or patient representative Date

CONTACT PERSONS WITH WHOM WE MAY DISCUSS YOUR CARE AND GIVE TEST RESULTS:

_____ _____ _____

Name Relationship Phone Number

_____ _____ _____

Name Relationship Phone Number

MAY WE LEAVE CONFIDENTIAL INFORMATION ON VOICE MAILS OR ANSWERING MACHINES LISTED BELOW:

Home Phone _____ _____ Yes _____ No

Work Voice Mail _____ _____ Yes _____ No

Cell Voice Mail _____ _____ Yes _____ No

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