Patient acknowledgement of receipt of HIPPA NOTICE

1) I acknowledge that I have reviewed or have been offered a copy of Seashore Women's Health Privacy Practices, effective 11/1/2014. __________ (Initial)

2) I acknowledge that I have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations, as long as this request is not reasonable. ________(Initial)

3) I would like Seashore Women's Health to use the following addresses and telephone numbers for appointment reminders or other office communications. Office communications may include, but are not limited to, billing matters, laboratory results, pathology results and imaging results. _________ (Initial)

   Phone:______________________ E-mail__________________________________

   Physical address: ____

4) Please list all persons with whom the patient will allow Seashore Women's Health to discuss or to leave messages regarding billing or medical information, including Patient Representative

   Not applicable/None: ___________________

   Name: ____ Phone: ___________________

   Name: ____ Phone: ___________________

   A current NOTICE OF PRIVACY PRACTICES for Seashore Women's Health is also available in the waiting area.

   Name (print)____ Date: __________________

   Signature of Patient or Patient Representative: ________________________________

   Relationship to Patient: ____