SOUTH VALLEY WOMEN'S HEALTH CARE

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I acknowledge that I was provided, a copy of South Valley Women's Health Care's Notice of Privacy Practice Form in accordance with the Federally Mandated H.I.P.A.A. Law. I have had time to read and review this Notice, and have had instructions given to me on how to obtain a copy for my personal records, should I desire.

Patient
Signature:_____

Patient
Name:_____Date:_____
(Please print)

MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) Act of 1996, was created with the sole purpose and goal of protecting patients medical records and financial information. We urge you to complete this form and allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I authorize the staff of South Valley Women's Health Care, P.C. to release any **MEDICAL AND FINANCIAL INFORMATION** to the following individuals:

SPOUSE: _____

PARTNER:_____

PARENT OR GUARDIAN:_____

OTHER:_____

Patient
Signature:_____Date:_____