• *ACKNOWLEDGEMENT OF PRIVACY PRACTICES*

I acknowledge that the Notice of Privacy Practices at A Woman's Place of Fort Collins, PLLC was made available to me. I understand that the HIPPA privacy rule gives individuals the right to request restriction on uses and disclosures of my protected health information (PHI).

_____ (Print Name)

• *EMERGENCY CONTACT* *(No medical information will be given to this person)*

_____	_____	_____
Name	Relationship	Phone Number

• *PATIENT RECORD OF DISCLOSURES*

I consent to A Woman's Place of Fort Collins, PLLC to use and disclosure of my PHI to carry out treatment, payment, and healthcare options.

_____ (Print Name)

To make it more efficient for A Woman's Place of Fort Collins to reach me, I wish to be contacted by the following **ONE** phone number for **ALL** medical and administrative purposes. This also allows any Staff member of A Woman's Place of Fort Collins to leave me a detailed message on my answering machine if I am unavailable.

Please circle type of phone: HOME / WORK / CELL

Phone Number: _____

I give my permission to release my medical information to the following family member(s), agent(s), or offices(s):

Name:_____ #:_____ Relationship:_____

Name:_____ #:_____ Relationship:_____

Name:_____ #:_____ Relationship:_____

☐Please check box if you give NO ONE permission to access your medical information.

I agree to update all contact information when changes occur.

_____	_____
Signature	Date