sacramentowomen's health
an ob/gyn partnership

ACKNOWLEGMENT OF PATIENT PRIVACY PRACTICE NOTICE

I have been informed of Sacramento Women's Health Patient Privacy Practices. I am aware that this notice describes how medical information about patients may be used and disclosed and how I can get access to this information. I have been requested to review it carefully. I am aware that I have the right to a paper copy of this notice and may ask for a copy at any time. I may obtain a paper copy of this notice by asking a staff member at the front desk or writing to: Sacramento Women's Health 2277 Fair Oaks Blvd. Suite 355, Sacramento, CA 95825.

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Obstetrics and Gynecology.

Name-*please print* _____

_____ _____
Signature of patient date

I authorize Sacramento Women's Health to release medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify Sacramento Women's Health, in writing, whenever this information changes.

Please think about listing the following people on this form:

- **Spouse/Parent/Significant other**
- **Person providing transportation to and from appointments**
- **Anyone you may ask to obtain appointment information**

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____ _____
Signature of patient Date