South Suburban Women's Center
13201 Granger Road, Suite 3
Garfield Heights, OH 44125
216-662-1900

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of South Suburban Women's Center. Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information (PHI) and your rights related to the Use and Disclosure of your Protected Health Information.

Our Notice of Privacy Practices is subject to change. If we change our Notice, the revised Notice will be posted in the office and on our website. You may obtain a copy of the revised Notice by: Asking the staff at the reception desk in our office or by requesting a copy from our office at South Suburban Women's Center, 13201 Granger Road, Suite 3, Garfield Heights, OH, 44125 or by calling 216.662.1900.

If you have any questions regarding our Notice of Privacy Practices, please contact our Privacy Officer.

I acknowledge receipt of the Notice of Privacy Practices

_____ _____
Print Name Relation to Patient

_____ _____
Signature Date

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason(s) why the acknowledgement was not obtained.

- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
  - ☐ Communication / Language Barrier
  - ☐ Other Reason: _____

_____ _____
Signature of Employee Date

South Suburban Women's Center

Communication of Protected Health Information

Patient Name: _____ Date of Birth: _____

Contact Preferences:

I wish to be contacted in the following manner for appointments and test results:

Home & Cell Phones:

- ☐ OK to leave a message with appointment date and time
- ☐ OK to leave a message with person answering phone
- ☐ OK to leave a message with test results
- ☐ Leave message with call back number only
- ☐ Do not leave a message

Work Telephone:

- ☐ OK to leave a message with appointment date and time
- ☐ OK to leave a message with person answering phone
- ☐ OK to leave a message with test results
- ☐ Leave message with call back number only
- ☐ Do not leave a message

Written Communication:

- ☐ May mail written communication to my home address: _____
- ☐ May fax written communication to this number: _____

Who To Contact:

I hereby give South Suburban Women's Center permission to disclose and discuss any information related to my medical information to/with the following family member(s), other relative(s) and/or close personal friend(s).

Name: _____	Relationship: _____	Phone #: _____
Name: _____	Relationship: _____	Phone #: _____
Name: _____	Relationship: _____	Phone #: _____

- ☐ I **do not** wish to give permission for any family members, relatives or close personal friends to have any access to any information regarding my medical condition or treatment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information not listed above or approved under the HIPAA Privacy Act will require specific authorization prior to disclosure of any information.

Print Patient or Legal Representative Name: _____

Sign Patient or Legal Representative Name: _____ Date: _____