

**By signing below, I hereby acknowledge receipt of the HIPAA PRIVACY NOTICE of WEST GEORGIA HEALTHCARE FOR WOMEN, P.C.**

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

I give permission to West Georgia Healthcare For Women, P.C. to disclose any information regarding my treatment to the following people in the event that they may need information about me over the telephone or in person:

**(\*\*PLEASE PRINT NAMES BELOW\*\*)**

- Spouse \_\_\_\_\_
- Parent(s) \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Friend(s) \_\_\_\_\_
- Other \_\_\_\_\_

\*\*\*\*\*

*(This section to be completed by West Georgia Healthcare For Women, P.C.)*

After a good-faith attempt to obtain an acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of West Georgia Healthcare For Women, P.C. Representative

\_\_\_\_\_  
Date