AWC
Anchorage Women's Clinic

ACKNOWLEGEMENT OF RECEIPT

Notice of Privacy Practices

I,_____, acknowledge and agree that I have been offered a copy of Anchorage Women's Clinic's *Privacy Practices.*

_____ _____

Signature Date

_____ _____

Patient Legal Representative Signature *(if applicable)* Date

_____ _____

Print name of Legal Representative Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but were unable due to:

_____

_____

_____

Anchorage Women's Clinic
You take care of everyone else, let us take care of you

Patient Name:_____

Access to Personal Health Information
Family and Friends

I authorize Anchorage Women's Clinic, LLC to discuss my personal health information, "PHI", with the following individuals:

1._____Relationship:_____

2._____Relationship:_____

☐ I do not wish for Anchorage Women's Clinic, LLC to discuss my personal health information with anyone.

By signing below you agree that Anchorage Women's Clinic, LLC may discuss "PHI" with the above individual(s). This will remain in effect for one year from the date signed below.

If you wish to cancel this you must do so in writing directed to:

HIPAA Compliance Officer
Anchorage Women's Clinic, LLC
3260 Providence Dr. Suite 425
Anchorage, AK 99508

Please call 907-561-7111 if you have additional questions.

Signature:_____ Date_____

Date of Birth:_____