HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

Park West Women's Associates, PLLC

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I hereby acknowledge that I have read and received a copy of the attached medical practice's **HIPAA Notice of Privacy Practices of the Park West Women's Associates.**

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of deceased patient

Name of Patient: _____

_____Do not write below this line_____

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