



The Doctors Women Trust - The Lifetime of Care They Deserve

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Orange Coast Women's Medical Group, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Orange Coast Women's Medical Group, Inc..

Signature of Patient

Name of Patient (Print or Type)

Date

Patient Account #

Secure Phone Option:

Is there a phone number on which personal health information could be left on your message recording in the event you are not available when we call? Y N

If 'Yes', what is that number? _____

Expanded Authorization Option:

Please list any persons you would like to authorize to have access to your billing, appointment or health information * such as your spouse, caretaker or other family member:

Name

Relationship

* With the exclusion of information that is protected under State or Federal law.

If Patient is a minor:

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Please note that State and Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.