

The Women's Pavilion, P.S.C.

PATIENT IDENTIFICATION:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, acknowledge by signing below that I have received a copy of this office's Notice of Privacy Practices.

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kind of information may be shared with each individual.

NAME	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appoint.	Medical	Billing/ Insurance
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific instructions or limitations: \_\_\_\_\_

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

To revoke this authorization, please send a written request to the address below:

The Women's Pavilion, P.S.C.  
1000 Breckenridge St, Ste 200  
Owensboro, KY 42303

If you have any questions please call The Women's Pavilion, P.S.C. at (270) 926-3700.