

# Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name: \_\_\_\_\_ Medical Record No.: \_\_\_\_\_

Address: \_\_\_\_\_

I have been given the opportunity to review Reproductive Health Center's Notice of Privacy Practices, which describes how my Personal Health Information (PHI) is used and shared. I understand that Reproductive Health Center has the right to change this Notice at any time. I may obtain a current copy by contacting the Reproductive Health Center's Privacy Official, or by visiting the Reproductive Health Center web site at [www.ivftucson.com](http://www.ivftucson.com)

My signature below acknowledges that I understand the Notice of Privacy Practices; additionally, I request the following method(s) of contact:

- Home phone \_\_\_\_\_
- Work/Business phone \_\_\_\_\_
- Personal cell phone \_\_\_\_\_
- Text message to cell phone \_\_\_\_\_
- Email \_\_\_\_\_

I also allow release of my PHI, including test results to the following individual:

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

\_\_\_\_\_  
Signature of Patient or Personal Representative: \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature RHC Representative: \_\_\_\_\_ Date \_\_\_\_\_

May2017

*Scan to patient's EMR original may be returned to patient*