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

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