

Notice of Privacy Practices Receipt

I acknowledge that ***Hygeia***: A Unique Center for Women's Health provided me with the Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

Chart Number: _____

Patient Signature: _____

Date of Signature: _____

If signed by a personal representative

Representatives Name: _____

Relationship to Patient: _____

Representatives Signature: _____

Date of Signature: _____

For Office use Only:

Signature of Employee: _____

Date of Signature: _____