Signature for Receipt of Patient Privacy Notice

I acknowledge that I have received a copy of the Patient Privacy Notice for South Lake Women's Health, P.C., office of Drs. Pamela R. Seaman and Dr. Merit D. Lemke.

I understand that my signature only represents my receipt of this Notice.

Print Name: _____

Address: _____

_____

Birth Date: _____/_____/_____

X _____ Date:_____

Patient Signature (Parent or Guardian must sign for minors)

Print Parent or Guardian name: _____

Please advise if there are any family member(s) with whom we may leave messages or discuss your medical record with:

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

Office use only:

Patient not present *Patient refused to sign*

Entered acknowledgement into the computer system by: _____