COMPREHENSIVE
WOMEN'S HEALTH

Patient Acknowledgement

Acknowledgement of Receipt of Practice Policies and Procedures (CWH)	
I, _____, have received a copy of the Comprehensive Women's Health Care Practice Policies and Procedures. I understand that I may access and download a current copy of these policies from the CWH website at any time.	
Patient Signature:	Date:

Acknowledgement of Receipt of Notice of Privacy Practices	
I understand that **Comprehensive Women's Health (CWH)** is a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and may share my Protected Health Information (PHI) for treatment, billing, and healthcare related purposes. My signature below constitutes my acknowledgement that I have been offered a copy of and had an opportunity to read the **Notice of Privacy Practices of Comprehensive Women's Health**. I understand this notice contains a description of the uses and disclosures of my personal health information and agree that my personal health information may be transmitted by computer to laboratories and or consulting health care practitioners to facilitate my medical care. I understand this information may be updated at any time and I can obtain a current copy of the Notice by contacting the office or downloading it from the CWH website. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines.	
Patient Name:	DOB:
Patient Signature:	Date:
CWH Witness:	Date: