Atlanta Women's Healthcare Specialists
Experienced. Compassionate. Collaborative.

Atlanta Women's Healthcare Specialists, LLC
275 Collier Road, NW Atlanta, Georgia 30309

Patient Name: _____ **Date of Birth: _____**
(Please print)

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices of Atlanta Women's Healthcare Specialists, LLC.

I understand that as part of my healthcare, the practices of Atlanta Women's Healthcare Specialists, LLC (AWHS) will need to contact me in order to remind me of an appointment, provide test results, give instructions, discuss billing, or provide other information. I understand that AWHS will use the minimum necessary information needed when communicating with me indirectly.

I further authorize Atlanta Women's Healthcare Specialists, LLC to discuss matters relating to my condition/care with the following persons and that this authorization will remain in place unless notified by me in writing:

_____ NONE (initial here)

_____ _____
Name of Authorized Person Relationship to Patient

_____ _____
Name of Authorized Person Relationship to Patient

_____ _____
Patient Signature **Date**