Cross Roads Woman's Health **Cross Roads Hormonal Health**

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the Cross Roads Women's Health & Cross Roads Hormonal Health, reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy in the physician's office and on the website. I may view a copy of the Notice of Privacy Practices at www.crwhealth.com or request a copy in person at my appointment.

______________________________	____________________
Patient's Printed Name	Date of Birth
______________________________	____________________
Patient's or Legal Representative's Signature	Date
______________________________	
Relationship to Patient	
______________________________	____________________
Witness	Date

I wish to be contacted in the following manner:

Home Telephone:
( ) Ok to leave message with detailed information
( ) Leave message with call-back number only
Cell Phone:
( ) Ok to leave message with detailed information
( ) Leave message with call-back number only
Work Telephone:
( ) Ok to leave message with detailed information
( ) Leave message with call-back number only

The following names are of people I would like to have access to my protected health information on a routine basis. I give permission for Cross Roads Women's Health, P.A. to share my protected health information with:

______________________________	____________________
Name	Relationship
______________________________	____________________
Name	Relationship
______________________________	____________________
Name	Relationship

Email to: smile@crwhealth.com