virginia physicians
FOR WOMEN

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclosed medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, ____ (please print name) have been provided with a copy of Virginia Physicians for Women's Notice of Privacy Practices.

I have had the opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Virginia Physicians for Women if I do not understand any information contained in the Notice of Privacy Practices.

____
Patient Signature

____
Date

____
Authorized Representative of Patient

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Relationship to Patient

____
Date