aventa
specialized women's care

Notice of Privacy Practices Acknowledgement

137 Clinic Drive
Dothan, Alabama 36303
phone 334-699-2229
fax 334-699-4084
web aventawoman.com

I, _____ , acknowledge I have received a copy of the notice of privacy practices.

_____ _____
Signature of Patient (parent/guardian if minor) Name of Patient (please print)

_____ _____
Relationship to Patient (or other authority to serve) Social Security Number of Patient

_____
Date

If patient or personal representative is unable or refuses to sign the form, document the reasons on this form. Place this form in the patient's medical record.

PERSONAL REPRESENTATIVE DESIGNATION

- Federal law states that Aventa Specialized Women's Care (Clinic) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving the Clinic permission to treat the person(s) you name as your Personal Representative, and to share your health information with that person.
- You can name more than one person as your Personal Representative.
- This Personal Representative Designation will last until you tell the Clinic you do not want it to treat the person(s) you name below as your Personal Representative any longer.
- Right to Revoke: if you decide you do not want the Clinic to treat the person(s) you name below as your Personal Representative any longer, sign the Revocation at the end of this form and give this form to the Clinic. Any Revocation can only apply on and after the date the Clinic receives the Revocation. The Clinic cannot cancel Disclosures it made to the Personal Representative before it received the Revocation.

I name the following person(s) to act as my Personal Representative: _____ _____
Name DOB

_____ _____
Name DOB

☐ This person has all the rights that I have regarding my health information that the Clinic has.

☐ This person is acting as my Personal Representative only for these functions:

Term of Authorization: The Clinic may share my health information from the date of this Personal Representative Designation until I revoke the Personal Representative Designation by signing the Revocation below, and giving the Revocation to the Clinic.

Signature _____ Date _____

REVOCATION:
I no longer want the person named above to act as my Personal Representative.

Signature _____ Date _____