Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ____, have received a copy of City of Oaks Midwifery's Notice of Privacy Practices.

____ ___________________________

Signature of Patient **Date**

Release of Information

○ I Accept
○ I Decline

Preferred Message Detail

	OK to leave detailed message	Leave message with call-back number only	Do not leave a message
Home	○	○	○
Cell	○	○	○
Work	○	○	○

Authorization: Written Communications

	Yes	NO
OK to mail to my home address	○	○
OK to mail to my work/office address	○	○
OK to contact Patient via fax	○	○

Medical Contact/Release of Information Permission for the following individuals:

Individual's Name	___________________________	___________________________
Phone Number	___________________________	___________________________
Relationship	___________________________	___________________________