



MIDWEST CENTER
FOR
WOMEN'S HEALTHCARE
*Exceptional **care** one patient at a time.*

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of Midwest Center for Women's HealthCare's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how Midwest Center for Women's HealthCare may use and disclose my confidential information.

I understand that Midwest Center for Women's HealthCare reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Signature

Date

If you are not the patient, please specify your relationship to the patient:

Relationship to Patient