ACKNOWLEDGEMENT AND CONSENT

I understand that Women's Health Center of Southern Oregon, P.C. (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information as described in a **Notice of Privacy Practices**.

I understand that the **Notice of Privacy** Practices may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:____ DOB: __________________________

(Patient)

Date:________________________________