EASTWIND WOMEN'S HEALTH, INC.

904 Eastwind Drive
Westerville, Ohio 43081
614-890-1914

Notice of Privacy Practices
Acknowledgement Form

Print Name: ____

Date: ____

CHECK AND SIGN OPTION ONE OR OPTION TWO BELOW, PLEASE.

OPTION ONE:

_____ I have received a copy of Eastwind Women's Health, Inc. (the "Practice")'s Notice of Privacy Practices.

Signature: ____

OPTION TWO:

_____ I was offered a copy of the Practice's Notice of Privacy Practices, but did not want it.

Signature: ____

For Office Use Only:

A good faith effort was made to provide a copy of the Practice's Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same.
The patient _____ accepted ______ declined the Notice and refused to sign this acknowledgement for the following reason: ____

Practice Representative: ____

Signature: ______________________________ Date: ___________

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