Taguchi Women's Clinic, PLLC
Alternative Contacts

Taguchi Women's Clinic takes your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with the person(s) you designate in the event that you are not available to receive phone calls or you have someone helping coordinate your medical care.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below.

This Authorization will remain in effect unless changed by me while I am a patient of this practice. It is my responsibility to notify this office in writing of changes and to complete a new form.

☐ I do not authorize anyone to receive information regarding my medical care.

☐ I authorize my physician and the clinic employees to speak with:

1. Person _____ Relationship_____
   Phone Number(s)_____
   ☐ Appointments ☐ Lab/Test Results ☐ Medical Care ☐ Billing
2. Person _____ Relationship_____
   Phone Number(s)_____
   ☐ Appointments ☐ Lab/Test Results ☐ Medical Care ☐ Billing
3. Person _____ Relationship_____
   Phone Number(s)_____
   ☐ Appointments ☐ Lab/Test Results ☐ Medical Care ☐ Billing

<u>Alternate means of contacting me are:</u>
Answering Machine/Voicemail/Pager_____ Fax_____
Email_____ Other _____

Patient Signature _____

Witness Signature _____

Date _____

☐ I do not wish to receive any e-mail communications from Taguchi Women's Clinic regarding services.

Taguchi Women's Clinic, PLLC

PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I have received a copy of the Taguchi Women's Clinic, Notice of Privacy Practices describing the practice commitment to privacy, my rights to privacy, and how Taguchi Women's Clinic, may use and disclose protected health information (PIH) about me to carry out treatment, payment, and healthcare operation (TPO).

By signing this form, I am acknowledging that Taguchi Women's Clinic, will use and disclose my protected health information to provide my medical care, receive payment for services provided to me, and to conduct its business.

I have the right to review the Notice of Privacy Practices prior to signing the acknowledgment.

_____ _____

Patient/Legal Guardian Signature Date

_____

Print Patient Name

_____

Relationship to Patient