Ashland Center for Women's Health, PLLC
J. Brian Frederick, MD – Tony W. Dotson, DO – Thomas L. Mahoney, MD
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Acknowledgement of Receipt of Privacy Notice

I, ______________________________ have been presented with a copy of Ashland Center for Women's Health, PLLC's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice and I request the following restriction(s) concerning the use of my personal medical information: ______________________________

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Any patient over the age of 18 is considered an adult and before any personal health information (PHI) may be released or discussed with anyone other than yourself we need your permission to do so.
I give my permission for the following PHI to be released or discussed to the following person(s)

Name ____________________ Relationship ____________________ # __________
Name ____________________ Relationship ____________________ # __________
Name ____________________ Relationship ____________________ # __________

- ☐ **Billing and account information**
- ☐ **Lab / Test results**
- ☐ **All Personal Health Information (PHI)**
- ☐ **Appt Reminder Cards and Reminder Calls**
- ☐ **Consent to Wireless Telephone Calls**

If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify ACWH to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the physician, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collections agencies.

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

Signed: ______________________________ DOB: ______________ Date: ______________

If not signed by patient, please indicate relationship to patient.

Relationship: ______________________________ Witnessed By: ______________________________

Office Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patent and sign below.

Presented on (date and time): ______________________________