



C R O S S W O O D S
W O M E N ' S H E A L T H

55 Dillmont Drive, Suite 102
Columbus, Ohio 43235

PATIENT ACKNOWLEDGEMENT FORM NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date: _____

I have received a copy of Crosswoods Women's Health Notice of Privacy Practices.

I was offered a copy of Crosswoods Women's Health Notice of Privacy Practices, but declined it.

Patient Signature: _____

A good faith effort was made to provide a copy of Crosswoods Women's Health Notice of Privacy Practices to this patient and to obtain her acknowledgement of the same.

Patient ACCEPTED DECLINED the notice and refused to sign this acknowledgement.

Crosswoods Women's Health Representative: _____

Signature: _____ Date: _____