By signing below I confirm that I have received a copy of the **Notice of Privacy Practices** booklet from **Foothills Center For Women, P.A.**

Signature_____ Date_____

Foothills Center for Women, P.A.

112 BOONE TRAIL
NORTH WILKESBORO, NC 28659
TELEPHONE: (336) 667-8241

FELLOW AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS

DIPLOMATE AMERICAN BOARD OF OBSTETRICIANS & GYNECOLOGISTS

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

LIMITATIONS AND RESTRICTIONS

Please describe any requested restrictions that you would like applied to your health information.

1. _____

2. _____

_____
Patient Name

_____
Patient Signature

_____
Date

*The Practice reserves the right to deny Limitations and Restrictions. Please refer to printed policy.