The signature below acknowledges a copy of this notice; Patient Privacy Practices was **RECEIVED** (not necessarily read). You may have received/read this on www.cornerstoneclinicforwomen.com and it is also available when you check in for you appointment.

Date

Patient (even if Minor) **or** Legal Representative

Message Consent: The Cornerstone Clinic for Women is dedicated to providing you fast and reliable information concerning your! care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. A convenient alternative is to leave a message or a text for you to check later. However, voice messages ***may contain*** confidential issues. *Text messages will contain information concerning appointments and weather related announcements only* and ***will not contain*** private patient health information. Please indicate your wishes below by simply **initialing and checking** one or more of the following choices. If you do not have any of the devices below, simply leave them blank.

NOTE: By checking one or more of the boxes below I authorize the staff of Cornerstone Clinic for Women to leave or transmit important and potential confidential information to one or more of the following:

Answering machine at the home telephone number

Voice mail at the work number ***only*** if the voice mail message has your name

Voice mail at the cell phone number

Text message to your cell phone

*****Do you check messages regularly? Yes No

NO ONE WILL BE ABLE TO ACCESS INFORMATION ABOUT YOU, EXCEPT YOU, UNLESS YOU FILL OUT THE BELOW ADDENDUM.

ADDENDUM: PATIENT PRIVACY

I ___________________________ authorize Cornerstone Clinic for Women to share pertinent "Protected Health Information" with my immediate family members or significant others, as noted below:

1. Allow Access for Patient Health Portal

Name

Date

Telephone Number

Alternative Number

2. Allow Access for Patient Health Portal

Name

Date

Telephone Number

Alternative Number

I understand that I may withdraw the above authorization at any time, with **written** request. I also understand that it is my responsibility to inform all family members or significant others to not disclose or use this information at any time or in any way without my permission. ***If you are a minor, you must complete the above fields in order for the clinic staff to be able to speak to anyone other than yourself.***

MINOR SIGNATURE - AGE 17 AND YOUNGER

DATE

PATIENT SIGNATURE

DATE